Caesarean Birth: Too Posh to Push, or Punished for Not Pushing?

Exploring Women's Experiences of Caesarean Birth

Leanne Taylor-Miller

The University of Auckland

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ABSTRACT
Caesarean birth is the mode of delivery for almost a quarter of births in New Zealand (NZ), and as the rate steadily rises, the expectation of a “natural birth” remains ubiquitous in society. Research investigating the impact of caesarean birth has previously demonstrated mixed findings regarding psychological outcomes, and recently caesareans have become topical with the addition of the idiom “too posh to push” to our lexicon. This implies that caesarean is an easy option, and may have shaped a sense of stigma against caesareans, particularly elective caesareans. The previous research demonstrating differences in psychological outcomes between planned and unplanned caesareans was conducted when caesarean birth was less common, and tended to be quantitative in design. The purpose of this qualitative research was to investigate the experiences of 32 women, including both first-time and non-first time mothers, who have undergone caesarean birth, half planned and half unplanned, in order to gain insight into their perceptions of their experiences and identify aspects that contributed to positive and negative experiences. Semi-structured interviews were used to explore their perceptions, including how they and others have reacted to their caesarean experience. These interviews were analysed using thematic analysis to identify themes to help to understand their experiences. This research supported a number of previous findings regarding caesarean birth including increased rates of induction associated with caesarean birth; differences in initial interaction between mother and infant for planned or unplanned caesareans; trust in medical experts; low occurrence of 'maternal' request for caesarean; and perceptions of societal attitudes towards caesarean. In addition, this research identified themes regarding the roles of expectations and preferences with the actual caesarean or breast feeding experience, influenced by individual and social factors. Negative outcomes were associated with a lack of reconciliation between actual experience, expectations and preferences; while positive outcomes were associated with effective reconciliation, through the development of rationales, applied both prospectively and retrospectively.
ACKNOWLEDGEMENTS

This study could not have been conducted without the participants who generously offered their birth stories for this research. They welcomed me into their homes while they discussed a deeply personal and monumental experience, and for that I am extremely grateful. I have grown through the experience of listening to their stories, and hope I have done them the justice they truly deserve. I am also thankful to the Plunket Society for their assistance and allowing me to access these participants.

I am very grateful for the support I have received from staff at the University of Auckland during the course of supervision for this thesis: Jackie Summers (who supported the original idea and helped design the research), Claire Cartwright, and Suzanne Barker-Collo. Suzanne has provided thought provoking feedback across all stages of the writing process which has had a considerable positive influence on the writing, and I am extremely grateful for her significant time and effort. I am also very grateful for the support from my workplace, particularly Karin Ruppeldt.

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<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
</tr>
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<tbody>
<tr>
<td>ACOG</td>
<td>American College of Obstetricians and Gynaecologists</td>
</tr>
<tr>
<td>APA</td>
<td>American Psychological Association</td>
</tr>
<tr>
<td>DMQ</td>
<td>Demographic Medical Questionnaire</td>
</tr>
<tr>
<td>GSSDH</td>
<td>Government Statistical Service for the Department of Health</td>
</tr>
<tr>
<td>HDWA</td>
<td>Health Department Western Australia</td>
</tr>
<tr>
<td>LMC</td>
<td>Lead Maternity Carer</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service</td>
</tr>
<tr>
<td>NWH</td>
<td>National Women's Hospital</td>
</tr>
<tr>
<td>NZ</td>
<td>New Zealand</td>
</tr>
<tr>
<td>NZHIS</td>
<td>NZ Health Information Service</td>
</tr>
<tr>
<td>NZMOH</td>
<td>NZ Ministry of Health</td>
</tr>
<tr>
<td>Plunket</td>
<td>Royal New Zealand Plunket Society</td>
</tr>
<tr>
<td>PND</td>
<td>Post natal depression</td>
</tr>
<tr>
<td>PTSD</td>
<td>Post traumatic stress disorder</td>
</tr>
<tr>
<td>TOL</td>
<td>Trial of labour</td>
</tr>
<tr>
<td>UK</td>
<td>United Kingdom</td>
</tr>
<tr>
<td>US</td>
<td>United States</td>
</tr>
<tr>
<td>USNIH</td>
<td>United States National Institute of Health</td>
</tr>
<tr>
<td>VBAC</td>
<td>Vaginal birth after caesarean</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
</tbody>
</table>
Preparing for the birth of her first child is a unique experience for every pregnant woman (Halldorsdottir & Karlsdottir, 1996). Whether a first time mother has decided to undertake detailed research before the event, or to simply enter into the experience without a great deal of fore-knowledge, she does not know exactly how the process will feel, how painful it will be, or how she will cope with the experience. Indeed, many women say that it is the unknown aspect of giving birth that makes waiting so difficult. For women who have already had a child, while they may have gained knowledge from the previous birth, this may contribute to either high or low expectations, serve as a template for a subsequent birth or as an example of “what not to do”, and it may either increase or allay fears. Despite this, any subsequent birth may still be completely contrary to expectations.

After the event, women compare birth stories in waiting rooms when their babies are weighed, at post-natal coffee groups, or at social gatherings when together with other mothers. This birth story, although its emphasis may change slightly depending on the audience, is an enduring one that remains with a woman forever (Weston, 2001). Indeed, the childbirth experience has been described as a critical life event that will forever influence a mother’s life (Fawcett, Pollio, & Tully, 1992; Marut & Mercer, 1979). Given the enduring nature and influence of birth stories, the question arises as to what happens when a woman’s expectations of the birth are in sharp contrast to the actual event? What happens when a carefully prepared birth plan becomes discarded at the early stages of labour, at the end of a long protracted labour, or before any labour at all? Or if the birth is contrary to the values a woman holds prior to the event, for example experiencing medical
intervention while holding a non-interventionist philosophy of natural birth. Similarly, what happens when the labour and birth are as expected, but a woman’s reactions to these are not?

It is difficult to avoid forming expectations or preconceptions about the birth process during pregnancy, particularly when surrounded by the images of birth presented in the media. These range from the joyous, clean and tidy event portrayed in some films, to the agonising ordeal presented in others. One particular aspect of childbirth that has received recent media attention is caesarean delivery. Newspapers offer articles titled “Too posh to push” (Fitzsimons, 2001) and “Why more babies are taking the short cut” (Jourdan, 2001), which imply that caesarean births may be an easier option than vaginal birth. Childbirth education classes may provide detailed information regarding caesarean deliveries or may simply include them only as a possible consequence of emergency complications. Furthermore, these classes may exhort the virtues of pain relief during labour, or imply failure for those that don’t stoically manage a “natural” labour.

The Researcher's Perspective

When conducting qualitative research, it is important to provide context for the study, and therefore provide information regarding the perspective of the researcher (Morrow, 2005). My interest in this area began with the birth of our son by caesarean section. After experiencing an enjoyable and problem-free pregnancy, I was stunned to have an emergency caesarean delivery following spontaneous bleeding at the commencement of labour. My surprise at requiring a surgical delivery gradually changed to a feeling of disappointment, a sense of “missing out”, and discomfort when birth stories were discussed, of feeling that I was not a member of “the club”. Since commencing this research (and prior to conducting research interviews) I have given birth to our daughter through a drug-free vaginal birth. These two differing births have given me the opportunity to contrast two completely different experiences. In the words of one of my participants, I have
learned that “caesarean or vaginal, they are both valid birth experiences”. However, when I began to look into the existing research regarding responses to caesarean births, I was surprised that although research investigates many aspects of caesarean births, women’s experiences expressed in their own words are rare.

**Rationale**

The aim of this research was to investigate women’s experiences and perceptions of caesarean birth to better understand the positive and problematic aspects that contribute to their perception of their experience. Women's difficulties regarding caesarean births have been documented in research findings and reported in the media, and it is therefore important to explore caesarean delivery with mothers in order to better understand what impacts their experiences. This study has clinical implications for women's experiences of caesarean and ways the birth experiences can be improved.

**Thesis Organisation**

The literature review which follows is intended to provide a background context to the research. An overview of pregnancy, labour and birth is given, followed by a section outlining caesarean delivery including: definitions and history of caesarean birth as well as describing the procedure; caesarean rates; factors influencing the rising rates of caesarean delivery; and classification (emergency/unplanned or elective/planned). This is followed by a discussion of some of the outcomes of caesarean delivery including: medical issues; the impact of repeat caesareans; psychological outcomes; reactions to the caesarean, bonding and the mother-infant relationship; and impact on breastfeeding. Finally, factors which are thought to influence the impact of the caesarean
section are discussed, including: whether the caesarean section was planned or unplanned; psychological integration of the process; and the content of antenatal classes.
CHAPTER 2.
BACKGROUNDS AND LITERATURE REVIEW

Pregnancy, Labour and Birth

The human gestation period is thirty eight weeks, but pregnancy is typically calculated from the last menstrual period and so is commonly regarded as having a duration of forty weeks. During this time, the cluster of cells formed after fertilisation will, on average, develop into a 55 centimetre long, 3.5 kilogram baby that somehow has to find its way into the world (Kitzinger, 1997). Globally 133-135 million births are predicted to occur annually for the next 25 years (United States (U.S.) Department of Commerce, 1996). In New Zealand (NZ) in 2003, 54,581 women gave birth to 55,289 babies (NZ Health Information Service [NZHIS], 2006). Two thirds of these women (67.4%) gave birth by ‘normal vaginal delivery’.

Vaginal delivery typically includes three stages of labour: the first stage of labour involves a period of regular contractions that accomplish the effacement (dilation) of the cervix to 10 centimetres which is sufficient for the passage of the foetal head; the second stage begins when the cervix is fully effaced and ends when the baby is born; the third stage begins after the baby is born and ends when the placenta and foetal membranes are expelled (Cunningham et al., 2005). Of women giving birth in NZ in 2003, 9.5% experienced operative vaginal births, which is a “vaginal birth that includes assistance using operative procedures” (NZHIS, 2006, p. 107), such as the use of forceps or vacuum (vontouse) extraction. The focus of this study was on caesarean section, which can occur either before or after the commencement of labour. In NZ in 2003 almost a quarter of birthing women (23.1%) gave birth by caesarean section (NZHIS, 2006).
**Caesarean Section**

*Definition, history and procedure.*

The Williams Obstetrics Guide defines caesarean delivery as “the birth of a foetus through incisions in the abdominal wall (laparotomy) and the uterine wall (hysterotomy)” (Cunningham et al., 2005, p. 588). The origin of the procedure is debatable, although it is popularly suggested that the name arises from the abdominal surgical delivery of Julius Caesar. This view has generally been discounted as it is recorded that his mother was still alive during his lifetime, and at that time the procedure was unfailingly fatal to the mother (Cunningham et al., 2005; Lawrence, 1997; Lurie, 2005).

Although there is considerable dispute within the literature, one of the first documented successful caesarean sections, resulting in a live mother as well as baby, was performed in Ireland in 1738 (Helen Churchill, 1995). Prior to this, the operation was typically conducted to save the life of the infant when it had been determined that the mother’s life could not be saved (Lawrence, 1997). Within the Christian world this was encouraged by the added incentive of extracting the baby for baptism in order to ensure its soul would be saved (Frazer, 1987). It was not until the twentieth century that caesarean deliveries consistently had positive outcomes for both mother and child. Maternal outcomes following the surgery have continued to improve with advances in anaesthesia (such as chloroform), sterilisation techniques that reduced infections, and changes to surgical techniques such as suturing (Cunningham et al., 2005).

Modern mortality rates associated with caesarean delivery are low, and although perhaps higher than mortality rates for vaginal delivery, depending on whether conducted under emergency or elective conditions, the absolute risk is low (Lang & King, 2008). Despite these low mortality rates, research reports higher risks of other complications with caesarean deliveries compared with vaginal delivery (Cunningham et al., 2005). For example, maternal morbidity research has found the
risk of endometritis (infection) up to 21 times higher following a caesarean delivery when compared to a vaginal delivery, with even higher risk when the caesarean follows a trial of labour (Burrows, Meyn, & Weber, 2004).

Modern day caesarean sections are performed after a regional or general anaesthesia has been administered and a catheter has been inserted (Kitzinger, 1997). Two types of regional anaesthesia are typically used: a spinal block is “the introduction of a local anaesthetic into the subarachnoid space” (Cunningham et al., 2005, p. 480), also used frequently during operative vaginal deliveries; or epidural analgesia which is achieved “by injecting a local anaesthetic into the epidural or peridural space” (Cunningham et al., 2005, p. 483). This form of anaesthetic is also commonly used during vaginal births for pain relief. The term ‘epidural’ is frequently used as an umbrella term to refer to all regional anaesthetics, including lumbar, spinal and epidural anaesthetics (NZHIS, 2006). These regional anaesthetics numb the patient while allowing her to remain awake during the delivery, as compared to general anaesthetic where the patient is rendered unconscious.

General anaesthetic is the most expedient to administer and involves the intravenous administration of an analgesia, inserting a breathing tube via the oesophagus (intubation), and administering a gas anaesthetic to keep the patient unconscious (Cunningham et al., 2005). Due to its rapid effect a general anaesthetic is most commonly used in urgent cases, but is usually the least preferred option from the patient's perspective, as the mother is unconscious when the baby is born (Kitzinger, 1997). Furthermore, the American College of Obstetricians and Gynecologists (ACOG) has recommended that, unless contraindicated, regional anaesthesia is preferable to general anaesthesia due to the higher risks associated with general anaesthesia (ACOG, 2004).

A review of the research into the effects of anaesthesia reveals relatively consistent findings, with general anaesthesia associated with more negative outcomes following caesarean delivery than epidural anaesthesia, regarding both physical and emotional reactions to the birth (Clement, 2001;
Fisher, Stanley, & Burrows, 1990; Garel, Lelong, & Kaminski, 1987; Reichert, Baron, & Fawcett, 1993). However, research has been mixed regarding emotional detachment between mother and infant following caesarean delivery, with Herishanu-Gilutz, Shahar, Schattner, Kofman, & Holcberg (2009) finding emotional detachment following emergency caesarean, particularly after general anaesthetic, while Figueiredo, Costa, Pacheco, & Pais (2009) found no association between emotional detachment and any anaesthesia, epidural or general.

Caesarean deliveries are typically performed via a horizontal incision low on the abdomen (commonly referred to as the ‘bikini line’), as this leads to less risk of the scar reopening during subsequent pregnancies than the historically preferred vertical incision (Cunningham et al., 2005). The incision is made through the abdominal wall to reveal the lower uterine segment, and then through this to reach the bag of amniotic fluid which is then pierced. The baby is then manoeuvred through this opening, often with some pressure on the upper side of the uterus to encourage the baby through the opening, and an injection may be given to encourage the placenta to detach from the uterine wall so it can also be removed through the abdomen (Kitzinger, 1997). Caesareans are typically completed in less than fifteen minutes, while the procedure of stitching the layers of the uterus and abdominal wall afterwards may take up to an hour (Kitzinger, 1997).

Until the mid 1970s, fathers were excluded from the operating theatre during caesarean births. At that time caesareans were treated solely as surgical procedures and it was viewed as unsafe, for hygiene and practical reasons, to have the fathers attend (Cohen, 1977; DiMatteo et al., 1996; Hedahl, 1980). Fathers now attend the majority of caesarean births, but are still excluded from the surgery if general anaesthesia is used (Kitzinger, 1997).

**Prevalence Rates.**

As noted previously, in 2003 in NZ 55,289 babies were born, and of these 23.1% were born via caesarean section (NZHIS, 2006). NZ’s rate of caesarean deliveries has steadily increased over
the last two decades, with the current figure in sharp contrast to the 11.7% reported in 1988 (NZHIS, 2004). This increase reflects an international trend, with most countries now having a caesarean rate well over the 10-15% still recommended by the World Health Organisation (WHO, 1985).

Published caesarean rates for a number of countries are presented in Table 1 which shows the trend of rising rates for the United Kingdom (UK), United States (US), Australia and NZ. Within NZ the highest rates are reported in the most populous areas.

<table>
<thead>
<tr>
<th>Author Extended</th>
<th>Year</th>
<th>Location</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>DiMatteo et al., 1996</td>
<td>2000</td>
<td>UK</td>
<td>19%</td>
</tr>
<tr>
<td>Government Statistical Service for the Department of Health, 2005</td>
<td>2004</td>
<td>England</td>
<td>22.7%</td>
</tr>
<tr>
<td>DiMatteo et al., 1996</td>
<td>1965</td>
<td>US</td>
<td>4.5%</td>
</tr>
<tr>
<td>Martin et al. 2005</td>
<td>2003</td>
<td>US</td>
<td>27.5%</td>
</tr>
<tr>
<td>Health Department of Western Australia, 2004</td>
<td>2000</td>
<td>Australia</td>
<td>23.5%</td>
</tr>
<tr>
<td>Gee et al., 2006</td>
<td>2004</td>
<td>Australia</td>
<td>29.4%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Western Australia</td>
<td>32.4%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Queensland</td>
<td>31.4%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- New South Wales</td>
<td>27.2%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Tasmania</td>
<td>26.6%</td>
</tr>
<tr>
<td>Chou, et al., 2006</td>
<td>2003</td>
<td>Taiwan</td>
<td>35.4%</td>
</tr>
<tr>
<td>New Zealand Health Information Service (NZHIS), 2004</td>
<td>1988</td>
<td>NZ</td>
<td>11.7%</td>
</tr>
<tr>
<td>NZHIS, 2003</td>
<td>2000</td>
<td>NZ</td>
<td>20.8%</td>
</tr>
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<td></td>
<td>2001</td>
<td>NZ</td>
<td>22.1%</td>
</tr>
<tr>
<td>NZHIS, 2004</td>
<td>2002</td>
<td>NZ</td>
<td>22.7%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Auckland a</td>
<td>25.7%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Canterbury b</td>
<td>28.8%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Northland c</td>
<td>13.6%</td>
</tr>
<tr>
<td>NZHIS, 2006</td>
<td>2003</td>
<td>NZ</td>
<td>23.1%</td>
</tr>
</tbody>
</table>

a Auckland Central is part of Auckland, NZ’s largest city
b Canterbury encompasses the Central East Coast of the South Island of NZ, including the city of Christchurch
c Northland is the region which encompasses the Northernmost area of NZ’s North Island, and has a low population density

The WHO recommended caesarean rate was published following a finding that perinatal mortality rates did not necessarily improve with increasing caesarean rates (WHO, 1985). The
difference between this recommendation and current actual rates is clear, but the reasons behind this difference are not immediately evident. There remains contention regarding the ideal rate of caesarean deliveries, with a number of articles, letters and commentaries continuing to debate this issue (Anonymous, 1997; Ash, 1997; Groom & Brown, 2000; Matthews et al., 2003; O’Connell & Lindow, 2000; Resnik, 2006; Sachs, Kobelin, Castro, & Frigoletto, 1999).

There are numerous reasons for caesarean delivery, with some more common than others. Currently in the US 85% of caesareans are performed due to previous caesarean, dystocia, foetal distress, or breech presentation (Cunningham et al., 2005). Dystocia is a heterogeneous term that includes most elements of ineffective labour including cases when the foetus is too big or the pelvis too small (cephalopelvic disproportion), the foetus is in an awkward position, or where there is failure to progress (i.e., a lack of cervical dilation or baby not descending) (Cunningham et al., 2005). In 2003 in Western Australia the most common reasons recorded for caesarean sections included: “previous caesarean section or other uterine surgery (26.7%); foetal distress (11.4%); placental disorders and/or haemorrhage (11.0%); obstruction or delayed labour (9.9%); breech and other malpresentation (9.2%); and cephalopelvic disproportion (7.3%)” (Health Department of Western Australia (HDWA), 2004, p. 21).

Factors Influencing Caesarean Rates.

The increase in caesarean rates over recent decades cannot be fully explained by any single factor. Instead, there are multiple factors contributing to the burgeoning number of surgical deliveries, including the finding that caesarean rates rise with maternal age, and the average maternal age is rising (Cunningham et al., 2005). The average age of mothers giving birth in NZ in 2003 was 30.2 years, with nearly one third of mothers aged between 30-34 years (NZHIS, 2006). This represents the continuation of a two-decade trend of increasing maternal age (NZHIS, 2004). As can be seen in Table 2, in NZ in 2003, 35.8% of women over the age of forty had a caesarean delivery,
compared with only 15.3% of women aged between 20-24 (NZHIS, 2006). The association between rising maternal age and caesarean section rates can also be seen in data from the US. Women aged under twenty who gave birth in the US in 2003 had a caesarean rate of 19.1% compared to: 26.4% for women aged between 25-29; 36.8% for women aged between 35-39; and 42.5% for women giving birth who were aged over forty years old (Martin et al., 2005).

Table 2. Mothers, by age group and type of birth, in New Zealand (NZ) in 2003 (NZ Health Information Service, 2006)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Normal Births</th>
<th>Caesarean Section</th>
<th>Operative</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 16</td>
<td>129</td>
<td>14</td>
<td>14</td>
<td>0</td>
</tr>
<tr>
<td>16-19</td>
<td>2888</td>
<td>484</td>
<td>415</td>
<td>69</td>
</tr>
<tr>
<td>20-24</td>
<td>7295</td>
<td>1456</td>
<td>1072</td>
<td>384</td>
</tr>
<tr>
<td>25-29</td>
<td>9485</td>
<td>2816</td>
<td>1873</td>
<td>943</td>
</tr>
<tr>
<td>30-34</td>
<td>10,608</td>
<td>4435</td>
<td>2680</td>
<td>1755</td>
</tr>
<tr>
<td>35-39</td>
<td>5321</td>
<td>2737</td>
<td>1449</td>
<td>1288</td>
</tr>
<tr>
<td>40+</td>
<td>1058</td>
<td>683</td>
<td>329</td>
<td>354</td>
</tr>
<tr>
<td>Total</td>
<td>36,784</td>
<td>12,625</td>
<td>7832</td>
<td>4793</td>
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</tbody>
</table>

Note. The Auckland District Health Board area (where this research took place) had a Vaginal Birth rate of 60.4%, and total Caesarean rate of 25.7%.

Induction of labour is also associated with increased rates of caesarean delivery (Cunningham et al., 2005). Induction of labour can be defined as “an intervention undertaken to stimulate the onset of labour by pharmacological or other means” (NZHIS, 2006, p. 106). Induction of labour may be initiated by pharmacological means (e.g., Prostaglandin or Oxytocin) or mechanical/surgical techniques such as artificially rupturing the membranes (Government Statistical Service for the Department of Health [GSSDH], 2005). The frequency of induction is increasing, with the numbers in the US almost doubling from 20% in 1989 to 38% in 2002 (Cunningham et al., 2005). In NZ in 2003, 19.7% of labours were induced (NZHIS, 2006).
The National Health Service (NHS) in England found caesarean rates were more likely to increase following induction, particularly when pharmacological rather than surgical techniques were used to induce the labour (GSSDH, 2005). Labours that are started by artificial interventions may lack some of the physiological processes or cervical ripeness (readiness) that are present in labours that start naturally, thereby perhaps reducing the likelihood of vaginal birth (Vrouenraets et al., 2005).

In 2003 in Western Australia 50.8% of labours were spontaneous, 29.4% induced, and the remaining 19.8% of women experienced no labour (HDWA, 2004). When the onset of labour was spontaneous, three quarters (78%) of the deliveries were spontaneous vaginal deliveries, 11% were instrumental vaginal deliveries, and 11% were emergency caesarean deliveries. When labours were pharmacologically induced, two thirds (65%) of deliveries were spontaneous vaginal deliveries, 14% were instrumental vaginal deliveries, and 21% were emergency caesarean deliveries (HDWA, 2004).

As can be seen in Table 3, in NZ in 2003 the induction rate increased with maternal age. These factors are likely to interact and increase the likelihood of caesarean delivery.

Table 3. New Zealand (NZ) rate of Inductions (per 100 births) by Age in 2003 (NZ Health Information Service, 2006)

<table>
<thead>
<tr>
<th>Age Group (years)</th>
<th>Inductions</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 16</td>
<td>15.0</td>
</tr>
<tr>
<td>16-19</td>
<td>17.8</td>
</tr>
<tr>
<td>20-24</td>
<td>18.1</td>
</tr>
<tr>
<td>25-29</td>
<td>19.3</td>
</tr>
<tr>
<td>30-34</td>
<td>20.1</td>
</tr>
<tr>
<td>35-39</td>
<td>21.1</td>
</tr>
<tr>
<td>40+</td>
<td>25.8</td>
</tr>
<tr>
<td>Total</td>
<td>19.7</td>
</tr>
</tbody>
</table>

Another pharmacological issue is the potential relationship between epidural anaesthesia and caesarean deliveries. This form of regional anaesthesia, defined previously, was used in 24.2% of
total live births in NZ in 2003, and the rate in the central Auckland region was 38.7% (NZHIS, 2006). Table 4 shows the rates of inductions and epidurals for NZ mothers in 2002, by birth type.

Table 4. Percentage of inductions and epidurals by delivery type in New Zealand (NZ) in 2002 (NZ Health Information Service, 2004)

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Normal delivery (%)</th>
<th>Acute Caesarean Section (%)</th>
<th>Other $^a$ (%)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both induction and epidural</td>
<td>44.4</td>
<td>30.8</td>
<td>24.7</td>
<td>100</td>
</tr>
<tr>
<td>Induction only</td>
<td>77.6</td>
<td>15.9</td>
<td>6.4</td>
<td>100</td>
</tr>
<tr>
<td>Epidural only</td>
<td>44.9</td>
<td>25.8</td>
<td>29.3</td>
<td>100</td>
</tr>
<tr>
<td>No induction or epidural</td>
<td>75.1</td>
<td>8.8</td>
<td>16.1$^b$</td>
<td>100</td>
</tr>
<tr>
<td>Over-all total</td>
<td>67.7</td>
<td>14.3</td>
<td>17.9</td>
<td>100</td>
</tr>
</tbody>
</table>

$^a$ Includes elective caesarean, breech extraction, forceps delivery, vacuum extraction  
$^b$ 12.2% were elective caesarean

Research has produced contradictory findings regarding the potential relationship between epidural anaesthesia and caesarean rates. Thorp et al. (1993) found significantly more caesarean sections were performed following the administration of epidural versus narcotic analgesia, primarily due to dystocia (ineffective labour) with prolonged first and second stages of labour, with further research finding a two to four-fold increased risk of caesarean delivery associated with the use of epidural analgesia (Ramin, Gambling, Lucas, Sharma, Sidawi & Leveno, 1995). However, more recently researchers have found that epidural analgesia can prolong the first stage of labour and significantly slow the rate of cervical dilation, with the authors suggesting this increase in labour time should be recognised as part of a functioning labour and not be prematurely diagnosed as dystocia (Alexander, Sharma, McIntire, & Leveno, 2002). Similarly, a recent meta-analysis found that although the length of both the first and second stages of labour may be increased with epidural analgesia, this had no effect on caesarean rates (Sharma, McIntire, Wiley, & Leveno, 2004).

The choice of Lead Maternity Carer (LMC) may also impact caesarean rates. In NZ, women may choose a midwife or an obstetrician or may opt for shared care with both a midwife and
obstetrician. National Women’s Health, a primary service provider of maternity care in central Auckland, NZ, reported that although their caesarean rate had stabilised at 29%, women had a 34.6% caesarean rate when their care was provided by a private obstetrician, with nearly one quarter of these being elective caesareans (Johnston, 2005). As can be seen in Table 5, in NZ in 2002, increasing maternal age (with the exception of those aged below sixteen) was related to the choice of an Obstetrician as the LMC.

Table 5. *Original Lead Maternity Carer (LMC) (%) by Mothers Age in New Zealand (NZ) in 2002 (NZ Health Information Service, 2004)*

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Midwife</th>
<th>Obstetrician</th>
<th>Other a</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 16</td>
<td>78.3</td>
<td>10.9</td>
<td>10.8</td>
</tr>
<tr>
<td>16-19</td>
<td>81.9</td>
<td>6.1</td>
<td>12.0</td>
</tr>
<tr>
<td>20-24</td>
<td>78.6</td>
<td>6.9</td>
<td>14.5</td>
</tr>
<tr>
<td>25-29</td>
<td>76.1</td>
<td>8.5</td>
<td>15.5</td>
</tr>
<tr>
<td>30-34</td>
<td>72.3</td>
<td>12.4</td>
<td>15.4</td>
</tr>
<tr>
<td>35-39</td>
<td>67.0</td>
<td>16.7</td>
<td>16.3</td>
</tr>
<tr>
<td>40+</td>
<td>62.6</td>
<td>20.2</td>
<td>17.2</td>
</tr>
<tr>
<td>Not reported</td>
<td>68.2</td>
<td>11.5</td>
<td>20.3</td>
</tr>
<tr>
<td>Total</td>
<td>73.1</td>
<td>11.2</td>
<td>15.7</td>
</tr>
</tbody>
</table>

a Includes General Practitioner and ‘Unknown’

There are a number of possible explanations as to why a higher caesarean rate was found with private obstetricians. It is accepted practice within NZ that, when under the care of a midwife, the LMC role may shift to an obstetrician if it becomes a high risk pregnancy or there are significant complications (Kutinova, 2008). Therefore, the 'choice' of an obstetrician may be associated with problem pregnancies (and older mothers) and therefore an increased likelihood of a caesarean delivery.

It is also possible that this heightened rate reflects obstetrician preferences for caesarean section, or alternatively it is possible that women who select a private obstetrician as their LMC may do so because of their own preference for a caesarean delivery, and may believe this is more attainable through an obstetrician than a midwife.
Research indicates women usually follow the medical advice of their medical advisors, and typically have a strong sense of trust in the knowledge of medical professionals (Crossley, 2007; Joffe, Manocchia, Weeks, & Cleary, 2003). Indeed, Joffe et al., (2003) suggest that it is this trust and confidence that is more important in medical care than involvement in decision-making, although did not specifically look at the birth process. The confidence in medical professionals however, is common at birth, with one study suggesting "women have great trust [that] the care midwives [or perhaps any medical professional] give them is the best care" (Sandin-Bojo, Larsson, & Hall-Lord, 2008).

There are a number of additional factors that are likely to contribute to the rising caesarean rate including the increased use of electronic foetal monitoring instead of intermittent auscultation which means an increased sensitivity and constancy of readings which could contribute to concern about the progression of labour (Graham, Petersen, Christo, & Fox, 2006). The notion of a "technocratic imperative" suggests technology that attempts to improve on nature frequently necessitates further technological intervention, which takes the process away from its original natural state (Davis-Floyd, 1994). This "medicalisation" of birth has been suggested as a significant factor in the rising caesarean rates (Johanson, Newburn, & Macfarlane, 2002). Other factors that possibly contribute to this rising rate include the increase in caesarean delivery of breech presentations, with caesareans frequently the standard practice rather than vaginal delivery (discussed further below); increased prevalence of maternal obesity which increases risk of caesarean delivery (Lynch, Sexton, Hession, Morrison, & Morrison, 2008); and the complicated interaction between clinical practice and concern about potential litigation if the birth outcome is negative, particularly in the US (Clark et al., 2008). Furthermore, the rates of caesarean birth are rising as the rates of vaginal birth after caesarean delivery (VBAC) decreases (discussed further below), contributing to a cycle of increasing caesarean births (MacDorman et al., 2008).
Finally, the rising caesarean rate appears to be influenced by more than the health and safety of the mother, foetus or characteristics of the labour, as research has found the likelihood of having a caesarean increases with higher socioeconomic status, availability of private health insurance, and delivery in a private or smaller hospital (Alves & Sheikh, 2005; DiMatteo et al., 1996; Gould, Davey, & Stafford, 1989). In particular, the idea that recent increases in the caesarean rate may be due to increased maternal request for 'elective' caesarean without medical indication has produced conflicting research findings (Bernstein, 2007; Gossman et al., 2006; MacDorman et al., 2008), with the issue of 'maternal request' caesareans, as well as both planned and unplanned caesareans, discussed below.

Caesarean Classifications - Elective and Emergency (Planned and Unplanned)

In addition to the numerous reasons for caesarean deliveries, the surgeries themselves are classified in one of two ways; either as ‘emergency’ caesareans, or as ‘elective’ caesareans. In NZ, emergency (unplanned) caesareans are defined as “caesarean section performed urgently for maternal or foetal health once labour has started” (NZHIS, 2004, p. 122). In contrast, elective (planned) caesareans are defined as “caesarean section performed before the onset of labour” (NZHIS, 2004, p. 122).

Thirty-eight percent of caesareans in NZ in 2003 were classified as elective (planned) caesareans (NZHIS, 2006). The term “elective” implies that these are chosen by the patient, and so this research will follow current convention and generally use the terms 'planned' and 'unplanned' when discussing the respective classifications (Lobel & DeLuca, 2007), although will use the terms 'elective' and 'emergency' when relevant to the context of the discussion. There are numerous medical reasons for planned caesarean deliveries, including complicated breech presentations, problems with previous vaginal deliveries and prior caesarean (Cunningham et al., 2005). In cases of prior caesarean or difficult previous vaginal deliveries, the form (vaginal or caesarean) for
subsequent births is typically taken on a case by case basis. However, breech presentations are frequently delivered by caesarean, with the NZ Ministry of Health (NZMOH) stating “caesarean has been shown to be a safer option than vaginal breech” (NZMOH, 2004, p. 2). The issue of recommended mode of delivery for breech presentations remains contentious, with the ACOG no longer advocating for caesarean delivery of breech presentations (ACOG, 2006), and others highlighting vaginal birth as a safe and appropriate mode of delivery for breech presentations (Kotaska, 2007).

In addition to the medical indications for planned caesareans, there are a number of non-medical reasons which include the convenience of a scheduled birth, fear of pelvic floor problems following a vaginal delivery, and a “deep-seated fear and lack of confidence” related to vaginal delivery (Wagner, 2000, p. 1678). Cultural factors have also been identified. For example, 45.1% of planned caesarean's were selected in order to ensure an auspicious ‘ba-tzu’ (birth horoscope) at a Taipei medical centre, with an overall caesarean rate of 41.5% at that setting (Huang, Yang, & Chen, 1997, cited in Chen & Wang, 2002).

Planned caesareans, particularly those for non-medical reasons, are especially contentious and still under debate, as these raise the need to weigh the potential risks of surgery with the right of mothers to make informed decisions regarding their own childbirth experience (Lobel & DeLuca, 2007). These elective caesareans have been associated with the phrase “too posh to push”. This idiom, generally referring to affluent women who allegedly choose a caesarean birth for reasons of convenience, is ubiquitous and can be found in popular magazines, newspapers and academic journal articles (Alves & Sheikh, 2005; Berry, 2007; Bourgeault et al., 2008; Fitzsimons, 2001; Lee, Savage, Beech, & Gillon, 2000; Song, 2004), and indeed media's use of "too posh to push" has itself become a topic of research (Berry, 2007). Alves and Sheikh (2005) described the term as referring to affluent women who elect caesarean delivery for “lifestyle reasons” (p. 994), and suggest their
findings of higher elective caesarean rates in more affluent areas (from analysing the maternity data from the Department of Health in England over a four-year period, 1996-2000) support the ‘too posh to push’ hypothesis. After excluding 1.5 million records that were incomplete, these authors analysed approximately 500,000 records and found, after adjusting for factors including age, that women from the most deprived quartile had a 26% less chance of delivering by elective caesarean than those in the most affluent quartile (Alves & Sheikh, 2005). However, as the specific reason for each caesarean was not indicated in the records, it is possible that a proportion of these caesareans were performed for medical reasons and not solely due to maternal request; and the high number of excluded records may have impacted the findings.

Eftekhar and Steer (2000) audited data from a central London Hospital in 1999, looking at the major indications for elective caesareans (as recorded in a planning book), and found elective caesareans made up 10.6% of the 3971 total recorded births. The authors proposed that 72% of the elective caesareans could ultimately be attributed to maternal request, suggesting caesarean would not have been suggested for medical reasons for the women with previous caesarean section (44%), maternal request alone (14%) and breech delivery (13%) (Eftekhar & Steer, 2000).

In a prospective study of planned caesareans, Jackson and Irvine (1998) collected data on caesarean's recorded from the total of 3025 births at a single hospital over one year, during which a caesarean rate of 18.8% was recorded with 276 (9.1%) elective caesarean's and 293 (9.7%) emergency caesarean's. Of the planned caesareans, 104 (38%) were classified as maternal request: 60% had experienced a previous caesarean section (with several who had experienced previous neonatal morbidity or mortality); 22% had breech presentation; 15% had previous perineal problems or a difficult delivery; 2% describing physical impediments to vaginal birth; with a single participant citing social convenience. In light of these medical histories, it appears the majority would have been under medical advisement regarding their impending delivery. Sixty-two per cent
of the planned caesareans were classified as medically advised due to previous caesareans with other concerns (including multiple previous caesareans and breech presentations), complicated breech presentations, or other obstetric indications (Jackson & Irvine, 1998).

As hospital policies regarding both VBAC and breech delivery are variable and typically involve increased medical intervention (such as increased monitoring and access to surgical facilities), it appears simplistic to suggest the reasons outlined above are interchangeable with ‘maternal request’ for reasons such as convenience. Jackson and Irvine (1998) acknowledged that the safest method of breech delivery is currently under debate, implying there may be legitimate safety concerns for vaginal breech delivery. Furthermore, they found that a previous caesarean was more likely to be medically indicated for a repeat caesarean than not medically indicated (35% versus 22%) suggesting that ‘maternal request’ is unlikely to be the primary reason for all repeat caesareans (Jackson & Irvine, 1998). The discrepancies in results between Jackson and Irvine (1998) and those of Eftekhar and Steer (2000) may be due to the method of data collection, with the latter's retrospective research limited to utilising abbreviated planning books, which may have obscured contributing factors for their finding of 14% maternal request alone caesarean's.

Prospective research conducted in Australia investigated 310 pregnant women's birth preferences and found that 93.5% of women preferred to have a spontaneous vaginal birth (Gamble & Creedy, 2001). Of the remaining participants who said they would prefer a caesarean, 95% had experienced either a previous complicated birth or were currently experiencing an obstetric complication, with only one participant without any medical indication and who reported a fear of labour and requested a general anaesthetic (Gamble & Creedy, 2001). As with Jackson and Irvine (1998) these findings are in contrast to the common perception of a high demand for elective caesareans for non-medical reasons.
All 282 obstetricians from Central London, a population presumably particularly informed regarding birth procedures, were sent an anonymous survey regarding their birthing preferences and were asked to reply on the pretext that they or their partners were pregnant for the first time with an uncomplicated pregnancy (Al-Mufti, McCarthy, & Fisk, 1997). Of the 206 replies, 17% chose an elective caesarean in the absence of any medical indicators, with 23 (31%) of female obstetricians making this choice. Reasons included fear of long-term sequelae, perineal damage and concern regarding future sexual function. When asked to imagine a breech presentation with no other complications, 57% of the obstetricians requested an elective caesarean. When the scenario was modified to suggest this breech presentation followed a previously successful vaginal birth, 40% would still opt for an elective caesarean delivery suggesting the classification of breech deliveries as 'maternal request' may contradict medical experience. Finally, a recent review of current relevant literature suggests very small numbers of women request caesarean section delivery, as shown by research evidence (McCourt et al., 2007). In addition, they suggest the importance placed on the advice of medical professionals significantly impacts the decision outcomes for birth method, with women frequently following advice of medical specialists (McCourt et al., 2007).

As with planned caesareans, the reasons for unplanned emergency caesareans are numerous, although in these cases the decision for caesarean is made after the commencement of labour. Reasons include maternal health (e.g., pre-eclampsia, high blood pressure), foetal health (e.g., foetal distress, malpresentation of the foetus, placental abnormalities including placenta previa) and problems during the labour (e.g., dystocia) (Boyce & Todd, 1992; Cox & Smith, 1982; Lurie, 2005).

Impact of Caesarean Section

Having presented definitions and prevalence of caesarean birth types as well as briefly examining factors influencing the likelihood of undergoing caesarean birth and contributing to
increasing caesarean rates, this review will now turn to the impact or outcomes of caesarean delivery. As the rate of caesarean deliveries increases internationally, there is a growing body of evidence which suggests that caesarean's can impact maternal functioning and outcomes in a number of ways including: medical issues related to recovery; the impact of repeat caesareans; psychological outcomes; reactions to caesareans (by self and others); the mother-infant relationship; and impact on breastfeeding following the birth.

**Medical Outcomes.**

Caesarean birth is linked to higher maternal mortality and morbidity and neonatal morbidity than vaginal births, although the absolute mortality risk of caesarean is still considered to be relatively low (Lang & King, 2008). Although previous research has found maternal death more likely following caesarean, particularly emergency caesarean (Hall & Bewley, 1999; Lilford, van Coeverden de Groot, Moore, & Bingham, 1990), some suggest maternal morbidity data may be a more functional and relevant measure of outcome than mortality statistics (Burrows et al., 2004). Caesarean births are associated with higher maternal morbidity, including hemorrhage; infection; injury to urethra, bladder and bowel; and has been associated with chronic pelvic pain (Almeida, Nogueira, Candido dos Reis, Rosa e Silva, & Almeida, 2002). Research reports post-operative pain following caesarean delivery (Keogh, Hughes, Ellery, Daniel, & Holdcroft, 2006; Nikolajsen, Sorensen, Jensen, & Kehlet, 2004), and there are also increased risks of endometritis (infection), need for transfusion, and incidence of pneumonia following a caesarean delivery (Burrows et al., 2004). After caesarean, subsequent pregnancies have an increased risk of placenta previa (where the placenta lies very close to the cervix); placenta accreta (where the placenta adheres abnormally to the uterine wall); uterine rupture; and peripartum hysterectomy when compared to births following a previous vaginal delivery (Leeman & LePlante, 2006).
In addition to maternal morbidity, infant morbidity has been found to increase following caesarean delivery when compared to vaginal delivery. A review of the records of 29,669 consecutive deliveries in the US found a five-fold higher rate of persistent pulmonary hypertension (a potentially fatal circulatory disorder) in infants who were delivered via planned caesarean (Levine, Ghai, Barton, & Strom, 2001). Rates of respiratory distress syndrome, a breathing disorder ranging from mild to potentially fatal, were also higher for infants born via caesarean section delivery than for vaginal delivery, even when pre-term deliveries, which have a higher incidence of respiratory distress syndrome, were excluded (Levine et al., 2001). It has been proposed that this higher risk may be due, at least in part, to the lack of chest compression that is associated with vaginal delivery, which helps the infant expel amniotic fluid from their lungs (Cunningham et al., 2005; Fogelson, Menard, Hulsey, & Ebeling, 2005). In the context of these findings, however, it is widely accepted that when the foetus is in distress, the benefits of a caesarean delivery significantly outweigh the potential risks (Wagner, 2000).

Repeat caesareans.

Since Craigin proclaimed “once a caesarean, always a caesarean” (Craigin, 1916, cited in Ugwumadu, 2005, p. 837), repeat caesareans have traditionally been the dominant approach for births following original caesarean delivery. This was due, at least in part, to the risk of the uterine scar rupturing during subsequent labour. This risk reduced to approximately 0.5% when the traditional vertical scar method was supplanted by the low-lying transverse incision (Leeman & LePlante, 2006). With this reduced risk of rupture and in light of escalating caesarean rates, recommendations from professional organisations such as ACOG and the US National Institute of Health (USNIH) began, in the 1980’s, to promote VBAC’s in the absence of contra-indicators as a safe birth choice (Zweifler et al., 2006). The rate of VBAC began to climb, peaking at 28.3% of all births after previous caesarean in 1996 (Martin et al., 2005). The numbers then began to decline,
possibly due in part to obstetrician's concern regarding potential complications (Zweifler et al., 2006).

In 1999 the ACOG issued a revision of the recommendations regarding VBAC with more cautious criteria including the need for an available emergency physicians to perform emergency caesareans if necessary, reiterating this more conservative stance in 2004 (ACOG, 2004). The declining rate of VBAC has resulted in a 2004 rate in the US of 10.6%, meaning if a woman experienced a caesarean birth, she has an almost 90% likelihood of subsequent deliveries being caesarean deliveries (Martin et al., 2005). Repeat caesareans make up more than one third of caesarean deliveries in the US (Zweifler et al., 2006). In NZ the rates of VBAC are higher, with the largest maternity service in Auckland (NZ's largest city) reporting 40% of women with a previous caesarean attempting a trial of labour (Pot, Sadler, Hickman, & Baird, 2008), although this has decreased from the 1992 VBAC rate of almost 50% (National Women's Hospital [NWH], 2000).

The degree of risk connected with VBAC is contentious and continues to be debated, with a lack of consistency among international recommendations and guidelines regarding VBAC (Foureur, Ryan, Nicholl, & Homer, 2010). The risk of uterine rupture following VBAC is typically cited as below 3%, and significantly increases with any kind of augmentation of labour (Dekker et al., 2010). Comprehensive research has indicated that a trial of labour (TOL) following a previous caesarean entails higher perinatal risk when compared to a repeat caesarean without a TOL, although they term the absolute risk as low (Al-Zirqi, Stray-Pedersen, Forsen, & Vangen, 2010; Landon et al., 2004).

Some researchers suggest that the maternal and foetal risks of attempting a VBAC are relatively small when compared to the negative morbidity, psychological effects, increasing financial costs and slower physical recovery that follow a caesarean delivery (Leeman & LePlante, 2006; Murphy & Harvey, 1989; Zweifler et al., 2006). McClain (1990) suggests that for the majority of women, a repeat caesarean has no medical benefits at all. The issue of VBAC remains contentious,
as it could be argued that the risks, while small, may not be justified in an era where elective caesareans are increasingly accepted (Cunningham et al., 2005). The risks of a VBAC, although low, may be too high for many women and unless there is a dramatic change in obstetrical practice or the advice offered to pregnant women, the figures for repeat caesarean births will continue to rise.

The normalising effect that is likely to accompany the increasing rates of caesarean delivery may also be contributing to the higher rates of repeat caesareans (McClain, 1990). Research has found women rely heavily on the advice of their medical carers, attending to both direct and indirect communication when considering VBAC and deciding on mode of delivery (Goodall, McVittie, & Magill, 2009). Qualitative research has found that women with a strong desire for the vaginal birth experience are more likely to choose VBAC, while those without this desire and who have previously experienced an unsuccessful labour that was long and debilitating are more likely to opt for an planned caesarean (McClain, 1985; Moffat et al., 2007; Murphy & Harvey, 1989). Researchers have also found that women are more likely to attempt a vaginal birth if they have previously experienced one (Eden, Hashima, Osterweil, Nygren, & Guise, 2004). This suggests that women who have already experienced success and have a sense of efficacy with vaginal birth, or those with a strong desire for a vaginal birth experience, may find it easier to choose a VBAC as compared to women who have experienced negative or unsuccessful labours or those for whom vaginal birth is unknown.

*Psychological Outcomes.*

As the rates of caesarean increase, there is considerable contradictory evidence regarding the myriad of reasons that caesarean deliveries may lead to negative psychological outcomes. The physical effects of anaesthesia, abdominal surgery and pain relief medication, in combination with undergoing a procedure that is frequently unexpected and almost always unfamiliar, can lead to a
number of emotions such as disappointment and anger and can affect the assimilation and integration of the birth experience (Cranley, Hedahl, & Pegg, 1983). Some researchers have suggested that experiencing a caesarean is the juxtaposition between the elation of having a baby and the jarring experience of surgery, and that this can lead to a difficult transition into parenthood (DiMatteo et al., 1996).

A number of researchers have found no negative emotional sequela to caesarean deliveries (Chen & Wang, 2002; Maclean, McDermott, & May, 2000; Sandelowski & Bustamante, 1986). For example, Maclean et al. (2000) found that women who experienced a caesarean delivery (either planned or unplanned) described the birth more positively than those who experienced instrumentally assisted vaginal deliveries. One explanation for this finding is that the experience of instrumental intervention is more traumatic than the controlled experience of surgery. Alternatively, the increasing rates of caesarean deliveries may have “normalised” caesarean births, and the possibility of increased social support associated with a surgical delivery may have a positive effect (Chen & Wang, 2002).

In contrast to these findings, there is a substantial body of evidence which suggests increased psychological morbidity following caesarean (Cranley et al., 1983; DiMatteo et al., 1996; Green, Coupland, & Kitzinger, 1990; Hannah, Adams, Lee, Glover, & Sandler, 1992; Keogh et al., 2006; Lobel & DeLuca, 2007; Marut & Mercer, 1979; Mercer, Hackley, & Bostrom, 1983), such as increased rates of postnatal depression (PND) (Astbury, Brown, Lumley, & Small, 1994; Boyce & Todd, 1992; Edwards, Porter, & Stein, 1994).

Birth, vaginal or caesarean, carries with it a risk of PND, with approximately 10-15% of all women being affected (Cunningham et al., 2005; Edwards et al., 1994). Although there is controversy regarding the potential link between mode of delivery and PND rates, a population based Australian study found increased rates of PND following operative birth (caesarean or forceps
deliveries) compared to spontaneous vaginal deliveries when assessed nine months postpartum (Astbury et al., 1994). Similarly, Boyce (1992) found a six-fold increased risk of PND three months after emergency caesarean when compared to spontaneous vaginal or forceps deliveries. Edwards et al (1994) also found increased rates of PND following caesarean section, but suggest that caesarean may ‘predispose’ to PND rather than cause it directly due to factors such as; anxiety during both pregnancy and labour; the lack of awareness of the birth when general anaesthesia is used; or a biochemical mechanism by which use of anaesthesia combined with surgery and hormones activated by childbirth increases the risk of PND (Edwards et al., 1994). However, a recent meta-analysis of relevant research found that no significant link has been established between PND and caesarean delivery (Carter, Frampton, & Mulder, 2006).

Fisher, Astbury and Smith (1997) investigated the relationships between the number of medical procedures undergone during the birthing experience and subsequent mood. Their prospective study of 272 Australian women found that while the number of medical interventions was not significantly related to mood, mode of delivery was associated with mood and self-esteem two months post-partum. Specifically, vaginal deliveries corresponded to better mood and self-esteem ratings, caesarean deliveries were associated with poor mood and self-esteem ratings, instrumental vaginal deliveries fell in between those for vaginal and caesarean births (Fisher et al., 1997). These findings were independent of self-esteem and mood ratings assessed late in pregnancy and any pre-existing psychopathology (Fisher et al., 1997). This finding supports previous research that found higher levels of medical intervention were associated with negative maternal psychological outcome following birth, with higher levels of technological assistance (culminating in caesarean deliveries) associated with the most negative outcomes (Oakley, 1980; Oakley, 1990).

In addition to PND and mood issues, due to the potentially traumatic nature of caesarean birth, post traumatic stress disorder (PTSD) outcomes have also been investigated. The prevalence
of PTSD following childbirth have been reported as ranging between 1.5-6% (Ayers & Pickering, 2001). Ryding, Wijma and Wijma (1997) examined whether caesarean birth could result in PTSD by sampling 25 women who experienced an emergency caesarean. They found that 76% met the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV) criteria for a traumatic event (American Psychological Association [APA], 1994), although none met the criteria for PTSD one to two months postpartum (Ryding et al., 1997). Creedy, Shochet and Horsfall (2000) utilised a prospective longitudinal design to investigate PTSD following birth in 499 women, with 28 (5.6%) meeting the DSM-IV criteria of PTSD at 6 weeks post-partum. They found that the risk of PTSD increased when a woman received a high level of obstetric intervention (e.g., emergency caesarean) and received (or perceived) poor maternity care (Creedy et al., 2000). A recent review confirmed findings of PTSD following birth and named obstetric complications, including caesarean birth, as one of a number of identified risk factors associated with the development of PTSD (Olde, van der Hart, Kleber, & van Son, 2006).

When trying to identify the mechanism to mediate between birth experience and emotional outcomes, authors such as Fisher et al. (1997) suggest that these findings support the tenet that a fulfilling childbirth experience includes active participation contributing to a sense of competence and mastery, and that distress may occur when this does not occur (Fisher et al., 1997). Personal control has also been associated with childbirth satisfaction (Goodman, Mackey, & Tavakoli, 2004). Others have found women frequently express less satisfaction with the experiences of caesarean versus vaginal delivery (Fawcett et al., 1992; Fisher et al., 1990; Garel et al., 1987; Padawer, Fagan, Janoff-Bulman, Strickland, & Chorowski, 1988). A review of research regarding satisfaction following birth found the majority of studies demonstrated the consistent finding of lower maternal satisfaction with the birth following caesarean delivery (Clement, 2001).
In addition to quantitative literature, there is qualitative evidence regarding the psychological impact of caesarean birth. Since Affonso (1977) first spoke of "missing pieces" following the experience of childbirth (Affonso, 1977, p. 159), research has frequently referred to a sense of loss following caesarean birth, particularly for first-time mothers (Clement, 2001; Cohen, 1977; Fenwick, Gamble, & Mawson, 2003; Fenwick, Holloway, & Alexander, 2009). Giving birth has been described as a once-in-a-lifetime experience and opportunity “to earn full status as mothers” (McClain, 1990, p. 208), with participants in subsequent research reflecting a sense of exclusion following caesarean birth, with one participant describing this as "I feel cheated because I have not experienced real childbirth. When you go through childbirth you sort of become part of this club, but before you have children you don’t know about it" (Fenwick et al., 2009, p. 561). Indeed, qualitative research has found that women frequently cite the desire to experience childbirth as an important reason to attempt a vaginal birth following a prior caesarean (Fawcett, Tulman, & Spedden, 1994; Gamble & Creedy, 2001; Kirk, Doyle, Leigh, & Garrard, 1990; McClain, 1990; Metcalfe, 1986; Moffat et al., 2007; Murphy & Harvey, 1989). A study of 32 women who experienced a successful VBAC similarly found that 70% would choose a vaginal birth for future deliveries as they felt more involved, had a better recovery and a better overall experience (Fawcett et al., 1994).

Feelings of guilt and failure have also been frequently described following caesarean deliveries (Berg & Dahlberg, 1998; Boyce & Todd, 1992; Clement, 2001; Cohen, 1977; Cranley et al., 1983; Donovan & Allen, 1977; Fawcett et al., 1992; Fenwick, 2003; Fenwick, 2009; Garel et al., 1987; Marut, 1978; Marut & Mercer, 1981). Qualitative examples from the literature demonstrate this sense of failure, with one participant reflecting on her caesarean, saying "I was an emergency caesarean because my cervix did not work. You don’t feel as though you are a woman and I thought I was a big failure " (Fenwick et al., 2009, p. 560); and another participant reporting “I was a failure, not a proper mum” (Clement, 1995, p. 29). Not all women who underwent caesarean deliveries
experience negative emotions, as there are positive comments have also been documented including "it hasn’t bothered me in the least having my babies this way" (Cranley et al., 1983, p. 12).

Much of the early qualitative research was conducted at a time when caesarean section rates were still below the WHO recommended rate of 10-15%, impacting expectations and familiarity with caesarean birth. It therefore appears relevant to re-investigate women’s attitudes regarding caesarean birth now they comprise a quarter of all deliveries, perhaps with attitudes changing due to increased prevalence.

Given the complexity of the above, it is not surprising that research has found it difficult to predict how women will react to a caesarean birth experience (Elliott, Anderson, Brough, Watson, & Rugg, 1984). Research has suggested a number of possible mediators of the caesarean birth experience, including information and preparation prior to the surgery; the presence of a support person; use of regional rather than general anaesthesia; physical contact with the baby straight after the birth; and degree of awareness and control as possibly aiding the prediction of outcome following caesarean birth (Bryanton, Gagnon, Johnston, & Hatem, 2008; Fisher et al., 1990).

Reactions to Caesarean.

Women are often asked about their birth experience by other women in informal social settings. This enquiry may create distress for women who gave birth via caesarean if they feel some sense of social judgement or stigma is attached to the caesarean birth experience (Lobel & DeLuca, 2007). Stigma is the negative social component to a condition or disorder, and is “characterised by the ignominy resulting from the social response” (Weiss, 2001, p. 19). Research regarding stigma associated with conditions such as epilepsy and psychological disorders note the distinction between the public and private experience of stigma, suggesting that stigma may be self-perceived and ‘felt’ as well as directly experienced, and can impact on psychosocial adaptation (Jacoby, 2002). Stigma, which has been called the “hidden burden of mental illness”, may arise from a range of conditions
and vary across cultures (Weiss, 2001, p. 19). Previous qualitative research, although not directly investigating stigma and caesarean delivery, has elicited comments that support the concept of perceived stigma such as “…there is something about having a caesarean, it is not normal. It is an abnormal process and other women look down on you because you had to have one” (Marut & Mercer, 1979, p. 264), suggesting stigma may potentially impact outcomes. Research regarding caesarean birth has referred to stigma indirectly, referring to the need to increase education regarding caesarean birth in order to "normalize" caesarean and to encourage "diminishing social stigma" (Lobel & DeLuca, 2007, p. 2278).

Caesarean birth may be viewed negatively due to its potential impact on mother-infant contact immediately following the birth, with research conducted to assess possible strategies to ameliorate any disruption of contact (Rowe-Murray & Fisher, 2001). Some authors have suggested that negative social judgement, enacted or perceived, may be at least in part due to a glorification of natural childbirth through the media and popular culture, exacerbating the idea that a caesarean birth may be the “ultimate catastrophe” (Clement, 1995, p. 28; Sandelowski, 1984). In addition, although the process of recovery from surgery is typically longer than that following a straight-forward vaginal birth, the popular media frequently implies that caesarean birth may be a symbol of status and an effortless alternative to vaginal birth (Fitzsimons, 2001; Tobias, 2004). This concept of "too posh to push", discussed earlier, implies caesarean birth is easier than vaginal birth and therefore, by association, women who choose this easy method by elective caesarean deserve even further disapproval (Berry, 2007).

*Mother-Infant Relationship.*

Initial contact between mother and infant is impacted by caesarean delivery, which in turn has been suggested to influence bonding, the onset of attachment suggested to occur during a critical period following birth (Klaus & Kennell, 1976). Attachment theory was developed by Bowlby
(1969) and describes the process of the development of the affective connection between the mother and infant (Brody, 1981). The theory suggests that infants, like other mammals, have a biological predisposition to be close to adults of their own kind and therefore exhibit crying, smiling and reaching and clinging as mechanisms to elicit maternal responses and facilitate the emotional bond between the mother and the infant (Bowlby, 1969). The suggestion of a critical period for the development of bonding followed observations that infants who failed to thrive or suffered from maternal neglect were frequently premature or had a neonatal illness which precluded close maternal physical contact immediately after birth (Brody, 1981). Furthermore, it was suggested that a history of separation and lack of attachment may contribute to the development of “affectionless characters”, clearly attributing long-term negative outcomes for the child to attachment difficulties (Bowlby, 1944; cited in Brody, 1981).

Similarly, Klaus and Kennell (1976) conducted research which demonstrated that skin-on-skin contact between mother and infant within an hour of birth resulted in more face-to-face contact when the infant was one month old. In contrast, other research has suggested that long-term effects of initial bonding are negligible, with attachments forming over a longer period of time (Brody, 1981; Eyer, 1994; Herbert, Sluckin, & Sluckin, 1982). One review of research regarding bonding suggested there was insufficient evidence to substantiate the concept of a critical period for establishing a mother-child relationship immediately following birth (Myers, 1984b). Further to this, Kennell and Klaus (1984) have clarified their position to state that, although they may speculate about a sensitive period to bonding, this is not the sole determining factor for the long-term mother-baby relationship.

Since the original research was conducted regarding bonding, research has suggested that caesarean delivery impacts initial mother and infant contact, with first mother-infant contact occurring later following a caesarean versus vaginal delivery, and 22% of caesarean mothers not
precisely remembering the first moment of contact (Garel et al., 1987). One woman described her experience stating “I wasn’t even awake … now I’m not even sure she’s mine … I have this dream where the nurse takes this baby out of the closet … and my baby is taken away. I’ll never really know if she’s mine” (Marut, 1978, p. 203). A study investigated mother-infant interactions of 169 participants at four and 12 months post-partum (Durik, Hyde, & Clark, 2000). They found no effect of birth type on mother-infant interactions, with the exception of poorer mother-child interactions four months post-partum for women who experienced unplanned caesarean birth and had recorded low antenatal neuroticism scores (Durik et al., 2000). The authors suggest that low neuroticism may lead to susceptibility to the potential negative effects of unplanned caesarean, and conclude there should otherwise be little concern regarding the quality of mother-infant interactions following caesarean birth (Durik et al., 2000). Therefore, caesarean delivery may have a negative impact on initial bonding due to separation of mother and baby, although long term effects are still being debated (Clement, 2001; Durik et al., 2000; Figueiredo et al., 2009; Fisher et al., 1990).

The negative consequence of the general acceptance of a critical or sensitive period is the potential for parents who cannot experience this close contact immediately following the birth to have a sense of guilt regarding this lack of contact (Myers, 1984a). The early researchers of bonding have acknowledged this issue (Kennell and Klaus (1984), and Shearer (1983) noted that “one can feel positively about the baby and negatively about the birth at the same time” (p.91), differentiating between the birth experience and any later relationship between mother and child. Current research regarding this issues has focused on the development of the more humanistic approach to caesarean delivery which has been adopted by hospitals, including the acceptance of a need for immediate contact between parents and infants following birth (Myers, 1984b; Rowe-Murray & Fisher, 2002).
Breastfeeding

Breastfeeding has also frequently been perceived as facilitating attachment and bonding (Else-Quest, Shibley, & Clark, 2003; Wilkinson & Scherl, 2006). A study of 570 mother-infant pairs found that breastfeeding mothers reported more attachment and infant reinforcement at four months, though no differences were found at twelve months, suggesting that any effects of breastfeeding on attachment may be short-term (Else-Quest et al., 2003). Other research has found that breastfeeding mothers spend significantly more time in mutual gaze with their infants and have more mutual touch and tactile stimulation of the infant, which could potentially facilitate the bonding process (Lavelli & Poli, 1998). Contrasting research conducted with 36 breast- and 24 bottle-feeding women with infants under six months old found no differences between the mothers in terms of psychological health and maternal attachment (Else-Quest et al., 2003; Wilkinson & Scherl, 2006). Although research regarding attachment and breastfeeding remains equivocal, as breastfeeding is typically initiated as soon as possible after the birth, it appears likely it would be impacted by the experience of the birth itself.

It is difficult to quantify the potential influence that caesarean deliveries may have on breastfeeding rates, in part due to the numerous reasons for caesareans (including maternal or infant health) which can directly affect breastfeeding success. For example, caesareans may be performed to deliver extremely premature infants who are then placed in special care units where breastfeeding may not be possible; alternatively caesareans may be performed when the mothers health is at risk and in need of treatment after the birth that could preclude breastfeeding (Cunningham et al., 2005). Research investigating pain following caesarean delivery found the presence of post-surgical pain negatively impacted initial breastfeeding (Karlstrom, Engstrom-Olofsson, Norbergh, Sjoling, & Hildingsson, 2007). Even without these medical issues, the time following birth before the first breastfeed is typically longer following a caesarean birth than vaginal births (Rowe-Murray &
Fisher, 2003), so it can be difficult to separate the effect of delayed initial feeding from any effects of the caesarean itself (Janke, 1988). Therefore, research findings have been mixed regarding the impact of caesarean deliveries on breastfeeding rates. One study found that self-reported “commitment to breastfeeding” had a more significant effect on breastfeeding than whether a woman had a vaginal or caesarean birth (Janke, 1988). Findings have also indicated that the delay before the first feed encounter following a caesarean birth was not associated with later breastfeeding failure (Janke, 1988; Kearney, Cronenwett, & Reinhardt, 1990; Rowe-Murray & Fisher, 2003).

However, it has been suggested that experiencing labour impacts initial breastfeeding due to the hormones that are stimulated and produced during the childbirth process, and their effect on lactation (Odent, 2004). If this is the case, there would be differences of initial breastfeeding success between planned and unplanned caesareans, as the latter occur in the absence of labour and therefore lack labour induced hormones. Research on this issue found lactation began earlier and produced more milk after a caesarean performed during labour when compared with scheduled caesarean births without labour, although the authors did not examine long term effects (Doganay & Avsar, 2002; Odent, 2004).

DiMatteo et al (1996) conducted a meta-analysis of 43 studies looking at differences between caesarean and vaginal deliveries in relation to a number of psychosocial outcomes. They found that women who experienced a caesarean birth were significantly less likely to breastfeed than those who experienced a vaginal delivery, and there was a larger effect when the caesarean was unplanned (DiMatteo et al., 1996). The duration of breastfeeding, once successfully started, was not differentially related to birth method. Therefore, it appears that caesarean birth may affect immediate breastfeeding experiences, but not any long-term effect. However, even a short-term effect could have a significant effect in NZ’s current pro-breastfeeding culture. Breast milk is considered to be the ideal infant food, with WHO recommending exclusive breastfeeding for six
months (WHO, 2001). The NZMOH is committed to implementing the WHO code, with the current policy exemplified in the catchphrase “breast is best” (Fielding, 1997). NZ’s initial rates of breastfeeding when leaving hospital are above 95%, and breastfeeding rates following this initial period can be seen below in Table 6.

**Table 6. New Zealand’s (NZ’s) Breastfeeding at 6 weeks, 3 months and 4-6 months (as percentages) as supplied by the Royal NZ Plunket Society (New Zealand Health Information Service, [NZHIS], 2006)**

<table>
<thead>
<tr>
<th>Year</th>
<th>Fully Breastfed (5-6 weeks) (%)</th>
<th>Fully Breastfed (3 months) (%)</th>
<th>Fully Breastfed (4-6 months) (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>65.1</td>
<td>50.7</td>
<td>a</td>
</tr>
<tr>
<td>2001</td>
<td>65.6</td>
<td>50.9</td>
<td>a</td>
</tr>
<tr>
<td>2002</td>
<td>66.3</td>
<td>55.2</td>
<td>23.0</td>
</tr>
<tr>
<td>2003</td>
<td>67.4</td>
<td>54.8</td>
<td>23.1</td>
</tr>
</tbody>
</table>

*a Figures could not be calculated

Thus, it is possible the rising breastfeeding rate, in conjunction with high initiation rates, may result in stigma or conflict for women who do not breastfeed or find it initially difficult, perhaps in response to caesarean delivery (Anonymous, 2003; Schmied & Barclay, 1999; Schmied, Sheehan, & Barclay, 2001; Vogel & Mitchell, 1998). Stigma, as previously discussed in connection with caesarean delivery itself, may also be perceived around breastfeeding. A sample of twenty-five Australian first-time mothers found that the public rhetoric of ‘breast is best’ contributed to the considerable pressure they felt to breastfeed (Schmied & Barclay, 1999; Schmied et al., 2001). Furthermore, the researchers found that many of the participants linked breastfeeding with their identity with being a mother, and success at breastfeeding was thereby considered a sign of being a “good mother” (Schmied et al., 2001, p 48). As feelings of guilt and lower self-esteem have previously been associated with caesarean birth, in addition to caesarean delivery possibly having a deleterious impact on initial breastfeeding, it is possible the interaction between these two processes may exacerbate potential psychological distress.
Summary of Outcomes of Caesarean Delivery

The foregoing section summarises the literature on the various outcomes of caesarean section delivery, including medical, psychological and social issues. This multitude of factors and their various possible interactions demonstrate the complicated interplay between caesarean delivery and subsequent outcomes following the birth. The next section discusses three of the factors which may impact the various aspects of outcome following caesarean delivery: whether the caesarean is planned versus unplanned; psychological integration of the experience; and information obtained through childbirth education classes prior to the birth.

Factors Influencing the Impact of Caesarean Section

Planned versus unplanned caesarean deliveries.

As defined previously, caesareans are classified as unplanned or planned based on whether the labour has commenced (emergency/acute) or has not commenced (planned/scheduled) when the decision to undergo a caesarean is made. Therefore, a planned caesarean delivery due to a breech presentation may become an emergency caesarean if the labour begins unexpectedly before the scheduled caesarean date. Research that has differentiated between emergency and planned caesarean deliveries reports that negative outcomes are more commonly associated with emergency caesarean deliveries (Clement, 2001; Cranley et al., 1983; DiMatteo et al., 1996; Durik et al., 2000; Garel et al., 1987; Lobel & DeLuca, 2007; Marut & Mercer, 1979; Ryding, Wijma, & Wijma, 1998; Waldenstroem, Hildingsson, Rubertsson, & Radestad, 2004). Other research has found no difference in outcomes between planned and unplanned caesareans (Astbury et al., 1994; Carter et al., 2006; Fawcett et al., 1992; Patel, Murphy, & Peters, 2005). DiMatteo et al (1996) conducted a meta-analysis of 43 studies looking at differences between caesarean and vaginal deliveries as well as further exploring differences between unplanned and planned caesarean deliveries. They found
that women were less satisfied with their birth experience following a caesarean as compared to vaginal birth, with a stronger effect for those who had unplanned caesareans. No differences between vaginal and caesarean birth were found on a number of other measures including maternal confidence, anxiety and stress (DiMatteo et al., 1996).

It has been suggested that the conflict between the expectation of a ‘normal’ vaginal birth and the reality of a surgical delivery can potentially lead to feelings of disappointment and failure (Boyce & Condon, 2001). Many women commence their pregnancy with an anticipation of a ‘natural’ vaginal birth (J. Fenwick, Gamble, & Hauck, 2006), and it may be this challenge to expectations that is deleterious rather than the surgical procedure itself (Cranley et al., 1983). Research by Ryding, Wijma and Wijma (2000), also suggest that it is the relationship between expectations and the subsequent reality of the birth experience that may impact perception of the caesarean experience, rather than the experience itself. They interviewed 25 women who had consecutive emergency caesarean deliveries in a Swedish hospital, 24 using general anaesthetic and one using regional anaesthetic. The women participated in semi-structured interviews 1-9 days after the birth, and were asked to describe their perceptions of the birth experience. A time-spatial model was used to assess the women’s narratives at six different phases of the birth experience: initial experience at the hospital; first beginning to sense the birth may be a caesarean; learning it would be a caesarean; experience in the operating room; when the woman woke; and when she saw her baby for the first time (Ryding et al., 2000). After analysing the qualitative data, the participants were classified into four groups, based upon their expectations when they first arrived in the labour ward: confidence whatever happens (n=5); positive expectations turning to disappointment (n=7); fears that come true (n=9); and confusion and amnesia (n=4). They were then re-interviewed up to two months later to investigate the presence of PTSD (Ryding et al., 1997). The researchers found that the participants classified as ‘confident whatever happened’ had the least traumatic perception of the
birth experience. These women reported that they felt they had participated in the decision to have a caesarean section, even though this was in all likelihood a medical inevitability, and the researchers suggest that their confidence and the relation between expectations and experience contributed to a feeling of control (Ryding et al., 2000).

When research was conducted to investigate factors that related to satisfaction with labour, they found higher satisfaction levels when birth expectations were met (Goodman et al., 2004). This offers a mechanism by which unplanned caesareans may lead to a more negative sequalae than planned caesareans, as unplanned caesarean typically have a brief time-frame between the decision for a caesarean and the surgery, which may impact feelings of control. Research has more generally found that perceived levels of control during the birth experience are correlated with later emotional well-being, with higher control associated with better outcome (Bryanton et al., 2008; Fenwick, 2009; Oakley & Rajan, 1990).

*Psychological integration of the caesarean experience*

As discussed earlier, the concept of a vaginal birth is socially promoted as the ideal birth method, yet women who are scheduled to have a caesarean delivery typically defend their impending birth method (Hauck, Fenwick, Downie, & Butt, 2007). How can this contradiction be reconciled: is it that all women who have scheduled caesareans are unusually indifferent to prospective birth method; or does something else occur?

Cognitive dissonance theory suggest people find it difficult to tolerate inconsistencies in cognitive processes, such as beliefs, knowledge or opinions about oneself, situations or the environment (Beasley & Joslyn, 2001). Originally proposed by Festinger (1957), cognitive dissonance theory suggests this psychological discomfort is reduced by the use of rationalisation or some other method to increase cognitive congruence. In other words, people tend to “bring preferences into line with expectations” (Kay, Jimenez, & Jost, 2002, p. 1300). Strategies for
reducing cognitive dissonance may include changing the relevant behaviour for future situations, changing the relevant beliefs, minimising the importance of the beliefs or breach of behaviour (including trivialisation), and reframing the circumstances of the situation to reduce culpability or responsibility (Stone, Wiegand, Cooper, & Aronson, 1997). In addition, Lyubomirsky and Ross (1999) suggested people may achieve this by enhancing the value of their own choice or circumstance and devaluing the alternative, while others suggest this may occur by generating new reasons or justifications for choices that may appear counterintuitive to their initial stance (Kay et al., 2002).

In effect, it has been suggested that people operate a “psychological immune system that serves to protect the individual from an overdose of gloom” (Gilbert, Pinel, Wilson, Blumberg, & Wheatley, 1998, p. 619), and this works best in a covert way that is not explicitly acknowledged. Although researches have differed in their specific models and processes, they all assume the premise of a psychological discomfort to incongruent cognitive elements (Beasley & Joslyn, 2001). In addition, it has been suggested that cognitive dissonance only occurs when the attitudes, beliefs or behaviour is considered by the individual to be somewhat relevant or important (Kay et al., 2002). If it is insignificant, they are unlikely to experience cognitive dissonance or follow strategies to reduce any dissonance.

Research regarding caesarean birth has referred to flexibility in attitudes following caesarean delivery, finding that even when the initial maternal response to a caesarean birth was negative (e.g., birth as disappointing), this could be counterbalanced by positive comments (e.g., at least a long labour was avoided) (Reichert et al., 1993). Crossley (2007) suggests flexibility in preferences and expectations prior to the birth may ameliorate the maternal reactions after a birth that does not follow the prescribed birth plan. Furthermore, sufficient time may be required in order to have the opportunity to effectively assimilate the experience. Early research found that people who
experienced caesarean birth clearly indicated "a strong need for time to adjust to the shock of their birth experience" (Marut & Mercer, 1979, p. 264). In addition, research has found women change their opinion about childbirth over time, although did not specifically examine differences between experiences of planned and unplanned caesarean (Waldenstrom, 2004). Therefore, it is possible that planned caesareans allow more time for the assimilation of the new expectation, leading to potential differences between emergency and planned caesareans.

Recent research has specifically looked at women’s expectations of childbirth and their subsequent perceptions of the experience, and referred to the psychological difficulty when these are contradictory (J. Fenwick et al., 2006; Hauck et al., 2007). Goodman et al. (2004) stated “apparently, congruency between expectations and the actual experience of childbirth leads to satisfaction with the experience” (p. 217). Fenwick et al. (2006) described the process of reframing as a way to cope with a shift of expectations for births following caesarean birth, while Hauck et al. (2007) specifically described the adaptation of expectations and attitudes for future births as a response to cognitive dissonance. Therefore, this may provide the means by which some who experience caesarean birth, whether planned or unplanned, can align attitudes with actual experience.

*Antenatal Education.*

Planned caesareans typically result in more positive outcomes than unplanned caesarean deliveries, so it would therefore seem logical that providing more information prior to a caesarean delivery could potentially reduce confusion and possibly increase any sense of control due to increased familiarity with the process (Churchill, 1997). In addition, others suggest the provision of information may impact decision-making for women considering caesarean delivery, and therefore possibly impact escalating caesarean rates (Irvine, 1999).

Previous research found that women reported a considerable need for more detailed information prior to their caesarean delivery (Fawcett, 1981; Fisher et al., 1990). Furthermore,
research conducted by Greene, Zeichner, Roberst, Callahan, & Granados (1989) on 42 participants who planned caesareans found additional education resulted in improved outcomes. However, research conducted between participants in normal versus ‘boosted caesarean information’ classes found that no significant difference on a number of subsequent birth measures such as pain, distress and self-esteem (Fawcett et al., 1993).

While research has found that women who have experienced caesarean delivery reported a need for more information prior to the birth, this is accompanied by an indication that they would probably have been unreceptive to this information during pregnancy when caesarean delivery was unanticipated (Garel et al., 1987). More recent research was conducted to evaluate the utility of the provision of information regarding caesarean birth to women during pregnancy (Walker, Turnbull, Pratt, & Wilkinson, 2005). The researchers found general resistance to information regarding caesarean during pregnancy, with most women expecting a vaginal birth and therefore not actively engaging in information regarding caesarean birth (Walker et al., 2005)

Summary

The foregoing literature points to an increasing rate of caesarean birth over time, with the common media suggesting this is due to maternal request, resulting in the idiom ‘too posh to push’. This is not borne out by the evidence and instead it is clear the escalating caesarean rate is impacted by a multitude of factors. It can also be seen that caesarean delivery impacts a myriad of dimensions of maternal outcome. These include physical and medical aspects of the caesarean, including the type of anaesthetic, and time taken before first contact with the baby following birth, as well as psychological and social aspects such as the extent of planning for the surgery, own responses and experiences of breastfeeding following the caesarean birth. These outcomes may be moderated by a number of factors, including the planned or unplanned nature of the surgery, psychological integration of the experience, and information gained through antenatal classes.
Qualitative Methodology

This is a qualitative study using interviews to investigate women’s perceptions of their caesarean experiences in order to gain insight into the aspects that contributed positively and negatively to their caesarean birth experiences. Qualitative research has been defined as the “study [of] things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them” (Denzin & Lincoln, 2005, p. 3). The current body of research regarding caesarean deliveries contains both qualitative and quantitative research designs, although it has been suggested that qualitative techniques may be the most appropriate method to look at complex issues, particularly those in public health (Baum, 1995).

Qualitative methods are frequently used in research that is exploratory, seeking hypothesis development, looking at sensitive issues, or wanting a breadth and depth of data that may not be accessible utilising quantitative techniques (Bowling, 2002). Therefore, qualitative methods are often used to study phenomenon or issues that are relatively unexplored or unexplained, or when the researcher believes the current theories around an issue may be flawed or incomplete (Morse & Field, 1995). The use of qualitative methods has been suggested as the appropriate technique for exploratory maternity research, providing the opportunity to inductively explore participants’ own experiences (Powell & Davies, 2001). Qualitative research is typically inductive, with theories and hypotheses often arising from the data rather than driving the data collected (Morse & Field, 1995).

In this research, the perspectives of the participants were investigated to gain a deeper understanding of how they constructed their birth experience, and to allow participants to raise any issues that have not yet been directly explored in research.

The interpretation of experiences can be taken from an etic or emic stance. Emic analysis is “interpreted from the author’s [participant’s] perspective … rather than analyzed from the
researcher’s perspective or from a prior framework or theory” (Morse, 1995, p. 242), while etic analysis is “the study and analysis of behaviour interpreted from the perspective of the observer” (Morse, 1995, p. 242). Qualitative methods have been noted as a useful strategy for uncovering emic views, which can then be used to develop useful and relevant theory (Guba & Lincoln, 1994). While these methods have previously been used to explore aspects of women’s birth experiences, many of these occurred when caesarean rates were much lower than current levels, and therefore it was potentially perceived differently. Given the context of rapidly changing caesarean rates, there may not be enough exploratory research on women’s perceptions of their own experience to confirm that any existing etic (external) theory is significant and relevant enough to explain the complete emic (insider) experience of caesarean section nor women’s perception of outcomes related to the experience.

Research has noted a need for in-depth qualitative research to investigate caesarean births (DiMatteo et al., 1996; Fisher et al., 1990; Simkin, 1991). More recently, Soet, Brack, & Dilorio (2003) noted a need for “in-depth qualitative research [that] should explore the connections between interaction with medical personnel, medical intervention, pain management, and perception of the birth experience” (Soet et al., 2003, p. 45). It has also been suggested that more attention needs to be paid to “how women felt during labour, their relationships with the staff, their feelings of control, and other more subjective features of labour and delivery”, as these may impact on later psychological states (Green et al., 1990, p. 16). By giving women the opportunity to relate their own experience without quantitative measures that could limit narrative, this research utilized women’s own narratives of their experiences and participants were given the opportunity to themselves direct the scope of the dialogue, thereby highlighting their own key reflections regarding their birth experiences.
Women may be more comfortable discussing their birth experiences in qualitative rather than quantitative research. Fawcett (1993) used seven quantitative questionnaires to investigate different aspects of post-birth outcomes, and experienced a 28% attrition rate over the course of the research. At least in part, this high attrition rate may have been due to the use of questionnaires, as reasons given for dropping out of the study included comments about to the questionnaire's “perceived lack of relevance … to their childbirth experiences” (Fawcett et al., 1993, p. 50). Furthermore, many women describe the feeling of being in their own “private world” during the labour and birth experience (Halldorsdottir & Karlsdottir, 1996). This would suggest their own words may be the best way to describe the experience, implying the appropriateness of qualitative research.

**Trustworthiness**

Although the issue of evaluating the quality of qualitative research has not yet reached consensus it is important to have an external standard to benchmark research against, to ensure that it remains of high quality and does not lose its integrity through the process of data collection or analysis (Silverman, 2005). Therefore, in order to assess the quality of qualitative research, a number of “trustworthiness” criteria have been proposed, which include the elements of credibility, transferability, dependability and confirmability (Guba & Lincoln, 1994). These parallel the conventional quantitative criteria of internal validity, external validity, reliability and objectivity. Credibility demonstrates the research findings accurately reflect the data, or in this case, the participant’s perceptions of their birth experience. To establish credibility, the procedure of data collection and analysis in this research has been clearly documented to help maintain the integrity of the process and document the rigour of the methodology. To confirm that the findings are considered reasonable based on the data, 12% of the interview data analysis and coding was confirmed by peer review, with the process of thematic analysis reviewed by a supervisor. Transferability demonstrates that research findings are more than anomalies and that they have
relevance in their particular field of research. The findings of this research, with themes transferable across participants, have been assessed for compatibility with other similar research projects. In this research the themes that were generated, although in some cases original, are in keeping with the existing body of research investigating caesarean birth. Dependability reflects the methodological rigour of the research, and as described throughout this methodology section, this research has been conducted responsibly and conscientiously. The data was collected, transcribed and coded using a transparent process and was checked via peer and supervisory review, endeavouring to ensure the quality of the research. Finally, confirmability refers to the accuracy of the findings of this research to the participant’s perceptions of their birth experiences. All participants were given the opportunity to provide feedback following the interviews, and the themes generated appear to confirm previous findings of caesarean research.

Methodological limitations

While qualitative research was the most appropriate method for this research, this limits the ability to deduce causality. However, the goal of this research project was not to assess for causality, but rather to enrich understanding of the birth narratives of women experiencing caesarean births and qualitative design allowed for the depth of inquiry necessary for such an investigation.

This research utilised the participant’s own perceptions of their birth experience, obviously a subjective view, and therefore limited in its ability to generate a universal theory which is generalisable to others. However, an enriched understanding of the caesarean birth process can contribute to the development of explanatory theory. Furthermore, research conducted to investigate the consistency of medical records with narratives of mothers regarding birth experiences have consistently found that women’s recollections of their birth experience were a reliable account of the child-birth experience (Hewson & Bennett, 1987; Quigley, Hockley, & Davidson, 2007; Troude et
Therefore, although subjective, that does not preclude these accounts being valuable contributions to the development of theory to explain the effects of the caesarean surgery.

In order to conduct qualitative research from a emic stance, it is important the data is not manipulated to fit with a predetermined theory (Morse & Field, 1995). In this case, the initial coding nodes were generated from the semi-structured interview, but a number of additional nodes were generated through the coding of the data to ensure that the coding nodes accurately reflected the content of the interviews. As stated, an independent coder was also given a sample of transcripts and their coding compared with that of the primary researcher, to ensure that the data was represented appropriately in the coding framework. Finally, as discussed, care was taken to ensure the ‘trustworthiness’ criteria proposed by Lincoln & Guba (1985) was met, and the data was treated with the respect and value it deserved.

Purpose of Research

The purpose of this study was to investigate women's experiences of planned and unplanned caesarean deliveries to gain insight into their perceptions of their experience and identify aspects that contributed to positive and negative experiences.
CHAPTER 3.

METHOD

Participants

The participants in this research were 32 women who had all given birth by caesarean section in the previous twelve months. The demographic details and some of the birth information for the participants are detailed in Table 7, grouped by type of birth (planned or unplanned caesarean). The mean age of participants was 33.6 years, and ranged from of 19-40 years. The only two participants aged under 30 both experienced unplanned caesareans.

Although 22 of the participants identified themselves as NZer/Pakeha/European, four identified as Maori or Pacific Island ancestry, with six other ethnicities identified (i.e., British Jamaican, Croatian, British, Chinese New Zealander, Dutch New Zealander, and Indian). The participants all lived in Central Auckland, with 30 of the participants married or partnered. The birth, typically occurring four months prior to the interview (ranging from 2.5-40 weeks) and was the first birth for two thirds of the participants.

Approximately one fifth of the women had experienced one or more previous caesarean births, and a similar number experienced a previous vaginal birth. There were no significant differences between the two groups, although participants who experienced unplanned caesareans were slightly less likely to be married, less likely to have tertiary education, and more likely for this to be their first birth, and therefore less likely to have a previous vaginal or caesarean birth. This information regarding the participants is detailed below in Table 7.
Table 7. Demographics and birth characteristics of the participant's, by type of caesarean birth (planned/unplanned)

<table>
<thead>
<tr>
<th>Mother Characteristics</th>
<th>Caesarean Type</th>
<th></th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Planned</td>
<td>Unplanned</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>N=16</td>
<td>N=16</td>
<td>N=32</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>35.1</td>
<td>32.1</td>
<td>33.6</td>
<td></td>
</tr>
<tr>
<td>Range</td>
<td>30-40</td>
<td>19-39</td>
<td>19-40</td>
<td></td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NZ/Pakeha/European</td>
<td>11</td>
<td>11</td>
<td>22 (69%)</td>
<td></td>
</tr>
<tr>
<td>Maori or Pacific Islander</td>
<td>2</td>
<td>2</td>
<td>4 (12%)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>3</td>
<td>6 (19%)</td>
<td></td>
</tr>
<tr>
<td>Relationship Status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>15</td>
<td>11</td>
<td>26 (81%)</td>
<td></td>
</tr>
<tr>
<td>Partnered</td>
<td>0</td>
<td>4</td>
<td>4 (13%)</td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>1</td>
<td>1</td>
<td>2 (6%)</td>
<td></td>
</tr>
<tr>
<td>Levels of education</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tertiary Education</td>
<td>16</td>
<td>13</td>
<td>29 (91%)</td>
<td></td>
</tr>
<tr>
<td>High School qualifications</td>
<td>0</td>
<td>2</td>
<td>2 (6%)</td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td>0</td>
<td>1</td>
<td>1 (3%)</td>
<td></td>
</tr>
<tr>
<td>Age of baby (weeks at interview)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>15.5</td>
<td>18.1</td>
<td>17.4</td>
<td></td>
</tr>
<tr>
<td>Range</td>
<td>2.5-32</td>
<td>7-40</td>
<td>2.5-40</td>
<td></td>
</tr>
<tr>
<td>Number of other children</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>9</td>
<td>13</td>
<td>21 (69%)</td>
<td></td>
</tr>
<tr>
<td>One</td>
<td>6</td>
<td>2</td>
<td>8 (25%)</td>
<td></td>
</tr>
<tr>
<td>Two</td>
<td>1</td>
<td>1</td>
<td>2 (6%)</td>
<td></td>
</tr>
<tr>
<td>Previous Vaginal Births</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>13</td>
<td>15</td>
<td>28 (88%)</td>
<td></td>
</tr>
<tr>
<td>One</td>
<td>5</td>
<td>0</td>
<td>3 (9%)</td>
<td></td>
</tr>
<tr>
<td>Two</td>
<td>0</td>
<td>1</td>
<td>1 (3%)</td>
<td></td>
</tr>
<tr>
<td>Previous Caesarean Births</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>12</td>
<td>14</td>
<td>26 (81%)</td>
<td></td>
</tr>
<tr>
<td>One</td>
<td>3</td>
<td>2</td>
<td>5 (16%)</td>
<td></td>
</tr>
<tr>
<td>Two</td>
<td>1</td>
<td>0</td>
<td>1 (3%)</td>
<td></td>
</tr>
<tr>
<td>Choice of LMC</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midwife</td>
<td>1</td>
<td>11</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Specialist</td>
<td>15(^a)</td>
<td>5</td>
<td>21</td>
<td></td>
</tr>
</tbody>
</table>

\(^a\) Two of the participants originally chose a midwife for LMC, but changed to the care of a specialist when a caesarean became planned  
\(^b\) One of these two participants attempting VBAC experienced the rupture of previous scar, which typically occurs in 1/200 VBAC deliveries.

Measures

Semi-structured Interview.

Semi-structured interviews were used to obtain the participants birth stories (see Appendix A). The interviews began with the open question “tell me about the birth of your baby”. The intention of starting with this very open question was for the participants to be given the opportunity
to describe the aspects of the birth that they found the most important or relevant to discuss. After
telling their story, the participants were asked to elaborate on various aspects of their experience.

Aspects of the interview schedule were adopted from the qualitative assessment of the Mills Longitudinal Study of Women's Mothering Experiences (Paris & Helson, 2002). This approach
breaks the birthing experience into the three major domains; pregnancy, experiences in labour and
childbirth, and reactions to the birth. This chronological sequence matches the narration of the
experience by many participants in birth research, so was considered appropriate for this study.
Areas of interest were also highlighted following a review of the caesarean section literature that was
conducted prior to the interviews. Fenwick (2003) identified six major factors that contributed to
women’s perceptions of their birthing experience: (i) being supported, (ii) violated expectations, (iii)
loss of control, (iv) health professionals language, attitudes and care practices, (v) the labour
experience and cascade of interventions and (vi), surgical birth and separation from the baby.

Therefore, the specific interest areas relevant to this research were: pregnancy (how was the
pregnancy, what were the expectations for the birth); the birth itself (what was the decision-making
process for the surgery, what was the reason given for the caesarean birth, any feelings of worry or
fear, feelings of control, support, and time before contact was had with the baby); reactions to the
birth (including the mothers own response and that of friends, family and acquaintances);
breastfeeding (if preferred, and if so, was this successful); other children (if they had other children
before this birth and if yes, how were they delivered and differences); and how the mother would
currently describe her child(ren).

In order to create a dataset that reflected the depth of these maternal experiences, a semi-
structured interview was considered to be the most appropriate. Such an interview allowed for
participants to provide the information that they found the most salient to their experience of birth,
while also providing leverage for the researcher to probe further for additional information whenever
appropriate clinically or contextually. At the conclusion of the interview, the participants were also asked if they had any additional comments that they wished to add to the interview.

Demographic and Medical Questionnaire (DMQ)

The DMQ was completed after the interview and comprised a one-page survey which covered demographic information and details regarding the caesarean birth (see Appendix B). The demographic questions included: date of birth; ethnicity with blank space for the participant to specify; highest level of education; relationship status (i.e., single, married, separated, divorced, partnered, other) and the age(s) of children (including children other than that of the latest caesarean birth). In addition to demographic questions, six questions were asked regarding the birth experience: the number of caesarean births, the number of non-caesarean births, whether the caesarean was planned, unplanned or other with blank space for the participant to specify; the main reason for the caesarean birth with blank space for the participant to specify; the anaesthetic type used for the caesarean delivery (i.e., general or epidural); and time passing after the caesarean birth before they able to see or touch the baby, with blank space for the participant to specify.

Procedure

Ethical approval for this study (reference 2005/017) was obtained from the University of Auckland Human Participants Ethics Committee. The Royal NZ Plunket Society (Plunket) was then approached to ascertain whether they would provide potential referrals of woman who have given birth by caesarean-section delivery. The Plunket Society was founded by Dr Frederick Truby King in 1907, and now provides support and practical help to parents with children under the age of five (Ryan, 1997). This includes home visits, regular weighing and measuring of infants, and assessments of typical developmental milestones such as sitting and crawling. Plunket's website
describes itself as “NZ’s leading provider of well child and family health services in NZ” (www.plunket.org.nz, 2006), and has contact with a significant majority (75-95%) of babies in their first year of life (Ryan, 1997). They were therefore chosen as a referral source because they access a wide range of women, thereby providing a broad recruitment source.

Ethical approval was obtained from the Plunket Ethics Committee, and the researcher met with a group of approximately fifty Plunket Nurses who work in the Auckland area. The research was discussed and the Plunket nurses were given the opportunity to ask questions. Approximately 100 packs of information were distributed to Plunket nurses who work in the Central Auckland Area (i.e., all central suburbs through to Avondale in the West, Mt Wellington in the South, Remuera in the East, and Central Auckland in the North). These information packs included a brief overview of the research for the Plunket Nurse (see Appendix C), a brief letter of introduction describing the research for the potential participant (see Appendix D), a Participant Information Sheet (see Appendix E), a Consent form (see Appendix F), and a postage-paid envelope in which to return the Consent Form. The Participant Information Sheet invited participation in the project, outlined the confidential and voluntary nature of participation, and contained the contact telephone number of the researcher so that potential participants could have the opportunity to ask any questions prior to involvement in the project. The Consent Form included a space for the potential participants to provide a contact telephone number.

Plunket nurses distributed the information packs as they came into contact with women who had recently had caesarean deliveries. It is not possible to calculate the response rate as it is unlikely that all the packs were given out. However, that 32 of the 100 distributed packets were returned suggests at least 32% response rate. The Plunket Society was informed after thirty participants were interviewed and told that no further referrals were required. Thirty was considered a sufficient number of participants for this research as, based on existing qualitative research, it was anticipated
that this would provide sufficient richness of data for the qualitative analysis. Two further Consent Forms were received after this notification, and these participants were also interviewed. The 32 referrals were generated within a three month period.

Upon receipt of completed consent forms, potential participants were contacted by the researcher using the telephone number provided to confirm their interest and schedule an interview. Thirty one of these interviews took place in the participant’s home, with one interview occurring in the private area of a café at the request of the participant. At each interview the potential participants were given a clear explanation of the study, the opportunity to ask questions and to withdraw their consent. No participants withdrew their consent before proceeding. Each interview was audio-taped and subsequently transcribed for analysis.

The semi-structured interview began by asking the participant to “tell the story of the birth, beginning wherever you like”. As much as possible, the participant was encouraged to explain what happened in their own words, using minimal encouragers. If the participant found it difficult to begin, more direction through the use of open questions was given to guide them. This was based on the semi-structured interview and was typically given as a chronological description of the birth beginning at pregnancy, or at the first indication of labour. At the conclusion, the researcher asked each participant to give more detail where clarity was lacking and, if not previously covered, the researcher made specific enquiries regarding the pregnancy, birth and reactions to the birth, as outlined in the Measures section. The questions were kept as open as possible in order to encourage the participants own narrative. The participants were also asked if they wished to add any further comments, or if they felt there was anything that had not been covered.

After each interview the researcher completed an entry into a field journal. These field notes typically included a brief description of each participant, and a summary of their birth story (see an example as Appendix G). This was utilised to aid the researcher’s familiarisation with the
participants and their stories, and to aid later recall. In order to minimise the impact of the researchers own caesarean experience on the interview dynamic, the personal birth experiences of the researcher were not disclosed prior to the interview unless specifically asked, which occurred with one participant. All participants were aware the researcher was also a recent mother with baby, aged between three to six months during the data collection process, present at each of the interviews. Most women directly asked the researcher about birth experiences at the conclusion of the interviews, but the comments during the interviews (e.g., “you know”, “ay”) gave the impression that most participants assumed that the researcher had also experienced caesarean birth. The researcher endeavoured to focus on each participant’s own individual experiences during the interviews, but acknowledge internally noting the differences and similarities between participants and personal experience.

At the end of the interview, the participants were asked to complete the medical and demographic questionnaire. This was not given before the participants described their experience, as it was thought this may have influenced their dialogue by potentially suggesting specific areas of researcher interest. At the completion of this, the participant’s were thanked for their participation and offered a list of post-natal support services available in Auckland. The interviews typically took approximately an hour to complete, although this ranged from 35 to 90 minutes.

The researcher then assigned each participant with a number, and their names were not used in analysis of the data. The sheet containing the names and numbers was stored securely in a separate location to the data. The interviews were transcribed verbatim, with all verbal utterances conveyed into written text. The text was transcribed as accurately as possible to reflect the actual speech, and included the grammatical errors, repetition and incomplete sentences that were used by the participants. Following transcription, all tapes were erased, required by the ethics committee.
**Data Analysis**

Thematic analysis is a qualitative method of data analysis that involves identifying common ideas or corresponding segments of meaning across the set of data. It has been described as “a method for identifying, analysing and reporting patterns (themes) within data” and is a popular method utilised within qualitative research (Braun & Clarke, 2006, p. 78). Themes have been described as “recurrent ideas or topics which can be detected in the material which is being analysed, and which come up on more than one occasion in a particular set of data” (Hayes, 2000, p. 173), or as something which “captures something important about the data in relation to the research question” (Braun & Clarke, 2006, p. 82). Thematic analysis chosen as the qualitative analysis method for this research as it is appropriate for research that is explorative, investigating the participants experiences (Braun & Clarke, 2006; Hayes, 2000) The number of times an idea is mentioned is not sufficient criteria for deciding whether the idea is a valid theme, instead it requires sufficient knowledge of the data to have confidence in the identification of appropriate themes (Bowling, 1997; Braun & Clarke, 2006). Themes can be generated at any stage of the research process, although most themes are either generated prior to data collection from a review of relevant literature, or are inferred from the actual data (Ryan & Bernard, 2000).

It has been suggested that the prevalence of a theme does not necessarily indicate its importance or validity, and there is no specific standards for how prevalence is represented when presenting qualitative data (Braun & Clarke, 2006). In this research the specific number of participants who refer to each theme has not always been indicated quantitatively, and instead a more qualitative description has been give to describe the proportion of the participants who referred to each theme. This will provide an indication of the approximate prevalence of a theme across the participants, without implying quantitative generalisability of the findings.
In an attempt to formalise the thematic analysis process, several researchers have outlined suggested processes and steps for thematic analysis (Braun & Clarke, 2006; Hayes, 2000). The overall methodology followed in this research used the phases outlined by Braun and Clarke (2006), shown in Table 8.

Table 8. Phases and Stages of thematic analysis as outlined by Braun and Clarke (2006, p. 87)

<table>
<thead>
<tr>
<th>Phase 1: Familiarise self with data (i.e., transcription)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase 2: Generate initial codes, coding across the data set</td>
</tr>
<tr>
<td>Phase 3: Search for themes, collating codes into potential themes</td>
</tr>
<tr>
<td>Phase 4: Review themes by checking against coded extracts and entire data set, including reanalysing and coding</td>
</tr>
<tr>
<td>Phase 5: Define and name themes</td>
</tr>
<tr>
<td>Phase 6: Produce the report, including a selection of illustrative quotations</td>
</tr>
</tbody>
</table>

In Phase 1, as familiarity of the data is an integral part of thematic analysis, each transcript was read a number of times before being coded one at a time into the N6 system. Each transcript was converted into a “text-only” format and then imported into the QSR N6 system. N6 “is the latest version of the NUD*IST software for qualitative data analysis” (Richards, 2002, p. 1), and allows the researcher to load, analyse, and code the data into nodes (and later into ‘themes’) without interfering with the integrity of the original data. ‘Lines’ were utilised as text units because, due to the verbatim nature of coding, some ‘sentences’ were more than ten lines long and covered a range of concepts. Therefore, when coding, any number of lines could be coded together to ensure the context of the text was retained.

In Phase 2, the N6 system utilises ‘nodes’ as “ways of abstracting from the data” and are the categories that can be used for coding (Richards, 2002, p. 35). The initial generation of nodes resulted from familiarisation with the data, as well as utilising the guide of the semi-structured interview, previously outlined in the Measures section. As the majority of the participants in this research used a chronological narrative, the majority of the initial nodes were clustered concerning pregnancy, labour, birth and post-birth. Additionally, the transcribing process and the use of field
notes had contributed to the researchers familiarity with the data and added to the awareness of certain aspects of the birth experience that were consistently raised by the participants (e.g. antenatal classes, 'experts'). Furthermore, additional nodes were added during the coding process (such as “unreal/surreal”, “too posh to push”) as it became clear each of these were recurring topics across the interviews. Transcripts that had been coded prior to each new node were re-read to ensure that they were accurately reflected in the new coding category. Data was coded in more than one node if it reflected more than one concept.

In order to ensure that the coding was correctly utilising the soft-ware program, the researcher met with a soft-ware expert after coding approximately ten interviews. The soft-ware expert confirmed that the initial selection of coding nodes, developing nodes, and the use of the software system was correct, and there were no suggested changes or modifications for effective use of the system.

It is important to confirm validity of the coding from an objective source. Approximately 12% of the interview data was peer reviewed to assess the appropriateness of coding. Each interview was coded by a qualified clinical psychologist who has experience with qualitative research, and this coding was compared with that of the primary researcher. This initial comparison revealed a high rate of inter-rater agreement, and any differences were discussed until the coding was mutually agreed upon.

In Phase 3, the nodes were re-examined to investigate how they could be clustered together to create potential global themes. This was done both intuitively, visually (with the use of diagrams of the varying ideas) and then were reviewed in order to ensure that they were coherent with the data.

In Phase 4 the themes were all reviewed to establish whether they were genuinely meaningful as overarching themes. All of the coded information below each theme was re-examined to check
whether they “formed a coherent pattern” (Braun & Clarke, 2006, p. 91), and the data-set as a whole was also re-examined to establish whether the retained themes created a coherent match with all of the data. This process was repeated until the themes created a congruent and coherent thematic map.

In Phase 5 the themes were refined and polished to ensure that they really encapsulated the essence of what they were trying to convey. This was to ensure that they were explanatory, rather than simply descriptive of the data, effectively conveyed their key ideas, and could concisely be described.

In Phase 6 the discussion section of this thesis was prepared at the conclusion of the data analysis, and was used to provide an accurate, coherent and informative explanation of the research findings. Extracts were used to best illustrate the key features of the finalised themes.
CHAPTER 4.

RESULTS

The interviews for this research were conducted after each participant experienced a caesarean delivery. When exploring the details of the surgical delivery, half of the caesarean deliveries were unplanned, and half of the participants experienced a planned delivery. Induction did not occur for any of the participants who planned a caesarean delivery. Of the 16 participants who planned a vaginal birth, one went into labour naturally without any medical intervention. Five of these participants began their labour naturally but had some form of medical intervention during the labour to expedite the process. Ten of the participants were induced, using gel or medication via a drip, to start their labour due to concerns regarding the mother’s health; concerns regarding the baby; or because the pregnancy had gone over forty weeks. The length of labour varied widely among the participants from brief to prolonged labour (ranging between 1-36 hours of labour) before culminating in caesarean delivery.

The four participants who experienced general anaesthetic all underwent unplanned caesareans. This is in keeping with general practice, with epidural the preferred anaesthetic unless contra-indicated, or urgent anaesthetising is required. The reasons for the planned caesareans were variable, including aspects of their previous caesarean for four of the participants, and breech presentation, pre-eclampsia, and trauma from previous birth for three participants respectively. Half of the unplanned caesareans were conducted due to 'failure to progress', with approximately one third due to foetal distress, and the remainder to other medical concerns. Two of participants who experienced unplanned caesarean were attempting VBAC (vaginal birth after caesarean), with their previous caesareans occurring due to breech presentation and failure to progress respectively.

The time before contact with the baby was variable across the participants, and ranged from 0 minutes ("immediately") for three of the participants, through to 12 hours ("the next day") for two of
the participants following both unplanned and planned caesareans. There was no significant
difference between groups although slightly more of the participants with unplanned caesareans had
a longer delay prior to the first contact with the baby following the birth. Fathers were present for all
of the births except for the two participants who were not in a relationship with the father of the baby
at the time of the birth, and the four participants who had their unplanned caesarean under general
anaesthetic. The factors that participants also discussed throughout the interviews are referred to in
various sections of the results section, and a summary of the medical outcomes are displayed below
in Table 9.

Table 9. Summary of Medical Outcomes of the caesarean for participant’s, by type of caesarean
birth (planned/unplanned)

<table>
<thead>
<tr>
<th>Medical Outcomes</th>
<th>Caesarean Type</th>
<th>Planned N=16</th>
<th>Unplanned N=16</th>
<th>Total N=32</th>
</tr>
</thead>
<tbody>
<tr>
<td>Induction</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nil induction</td>
<td></td>
<td>16</td>
<td>1</td>
<td>17</td>
</tr>
<tr>
<td>To start labour</td>
<td></td>
<td>0</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>After spontaneous start of labour, to</td>
<td></td>
<td>0</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>help speed/progress labour</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type of anaesthesia</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epidural/Spinal</td>
<td></td>
<td>16</td>
<td>12</td>
<td>28 (87%)</td>
</tr>
<tr>
<td>General</td>
<td></td>
<td>0</td>
<td>4</td>
<td>4 (13%)</td>
</tr>
<tr>
<td>Reason for Caesarean</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Traumatic previous vaginal birth</td>
<td></td>
<td>3</td>
<td>0</td>
<td>3 (9%)</td>
</tr>
<tr>
<td>Breech</td>
<td></td>
<td>3</td>
<td>1</td>
<td>4 (13%)</td>
</tr>
<tr>
<td>Previous complicated caesarean</td>
<td></td>
<td>4</td>
<td>0</td>
<td>4 (13%)</td>
</tr>
<tr>
<td>Retarded foetal growth in utero</td>
<td></td>
<td>1</td>
<td>0</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>Medical issues</td>
<td></td>
<td>2</td>
<td>1</td>
<td>3 (9%)</td>
</tr>
<tr>
<td>Failure to progress</td>
<td></td>
<td>0</td>
<td>8</td>
<td>8 (25%)</td>
</tr>
<tr>
<td>Baby in distress</td>
<td></td>
<td>0</td>
<td>6</td>
<td>6 (19%)</td>
</tr>
<tr>
<td>Pre-eclampsia</td>
<td></td>
<td>3</td>
<td>0</td>
<td>3 (9%)</td>
</tr>
<tr>
<td>Time before first contact with baby</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- 0-30 minutes</td>
<td></td>
<td>10</td>
<td>8</td>
<td>18</td>
</tr>
<tr>
<td>- 30-60 minutes</td>
<td></td>
<td>3</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>- 60-720 minutes (1-12 hours)</td>
<td></td>
<td>3</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Father present for the birth</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Present</td>
<td></td>
<td>15</td>
<td>11</td>
<td>26</td>
</tr>
<tr>
<td>- Not present</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- No partner</td>
<td></td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>- General anaesthetic</td>
<td></td>
<td></td>
<td></td>
<td>4</td>
</tr>
</tbody>
</table>

a During labour the hand of the baby was above the head  
b Complications included premature/small/very large babies in previous pregnancies, gestational diabetes, persistent posterior presentations  
c Includes prior heart/back surgery and fibroid blocking cervix  
d Includes “baby would not come down”, “baby stuck”, “baby in wrong position”, “baby too big”, “brow presentation”  
e Includes “induction due to age, baby in distress”, “no water around baby”
During the interviews, the participants typically described their birth stories in the chronological order of: pregnancy; labour; birth, including recovery; and reactions to the birth. If they did not spontaneously discuss each phase, they were gently asked to describe their experience of each stage. Thus, the results are presented in relation to pregnancy, labour, birth and reactions to the birth.

The interviews were repeatedly examined to identify, review and refine themes, using the process described earlier in the Procedure section. The themes that were consistent over the stages of the birth stories, as well as the data set, were conceptualised as: *Expectations and Preferences*; *Transition* (as circumstances changed); and *Justification and New Rationale*. A number of subthemes clustered under each of these, and are discussed in more detail throughout the following sections.

The designation for each theme was chosen as it seemed to best epitomise the underlying sentiments of the participants. For example, when participants used phrases such as “I want to …”, “hope to …”, “would like to …”, these were clustered under the heading of “preferences”. When participants used phrases such as “I plan to …”, “I thought I would …”, “I always knew I would …”, these were clustered under the heading of “expectations”. The term “transition” was used to describe aspects of the participant’s narrative when they appeared to experience incongruity between their expectations or preferences and their actual experiences, and the term “justification” was used to describe incidences when the participants appeared to rationalise or defend their decisions or actions.

The exceptions to these conceptualised themes of preferences, expectations, transition and justification occurred during the participant's descriptions of pregnancy, where the themes of: ambivalence; worry; and 'pro-natural' were identified. Although these themes did not re-occur across the stages of the birth stories, they occurred for the majority of participants when discussing
pregnancy, and therefore a brief section regarding this has been included in the Results section to accurately reflect the information discussed during the interviews. The results related to breastfeeding have also been given their own section, as although this was not intended to be a particular area of emphasis, the participant’s views on this topic were so numerous and emphatic that it justifies appropriate attention.

As discussed previously, the precise number of participants who referred to each theme has not been included, unless specifically relevant, to avoid the implication of quantitative methodology. Instead, a general indication of the proportion of participants who referred to each theme has been included to provide a sense of the prevalence of a particular theme across the participants in this research. For example, eight participants would equate one quarter of the total participants; 16 would equate half of the total participants; and so on, while terms such as "more than a quarter" will be used to describe the amount between one quarter and half of the participants. As discussed earlier, the terms ‘planned’ and ‘unplanned’ will be used to differentiate between caesareans that occurred with or without warning, following current convention (Lobel & DeLuca, 2007).

Quotes from the participants have been used throughout the Results section to illustrate each theme. Quotes that best encapsulated the essence of each theme were chosen, and the type of caesarean experienced by each participant (planned or unplanned) has been included in the reference for each quotation. During the data analysis process, mind-map diagrams were created as an additional way of organising and viewing the data, and these diagrams have been included for each stage of the birth story.

The Experience of Pregnancy

Pregnancy was the time when the participants not only experienced physical sensations, but also developed expectations, attitudes and preferences for their baby’s birth. As discussed earlier,
sixteen of the participants anticipated a vaginal birth throughout the whole course of their pregnancy, while sixteen of the participants became aware they would be having a caesarean birth at varying stages of pregnancy. During the interviews all participants were asked to recall the ideas they had held about childbirth during their pregnancy. The data has been separated below to demonstrate: themes that were identified regarding their experience of pregnancy; followed by themes regarding expectations and preferences for the impending birth that were held during pregnancy.

The participant's experienced a range of physical sensations during pregnancy, and themes that were identified when discussing the pregnancy were: ambivalence; worry; and 'natural is best'. These themes are discussed in more detail below, and shown in Figure 1.

Figure 1. Themes regarding the experience of pregnancy

Themes

Ambivalence - The experience of pregnancy varied widely across the participants, with varying degrees of morning sickness, nausea and physical discomfort described. However, when discussing pregnancy, more than three quarters of the participants described it as a positive experience. In addition, almost two thirds of the participants also referred to unpleasant side-effects they experienced, therefore demonstrating some ambivalence regarding pregnancy.

I loved being pregnant ...I was sick all the way through ... but other than that, I had a great pregnancy. Participant 122 (unplanned caesarean)
Only one participant openly stated she hated pregnancy. She experienced significant nausea for the majority of her pregnancy, which naturally impacted her experience. However, in spite of this, she still held some positive views regarding her pregnancy, once again demonstrating some ambivalence.

I was sick for about 6 months when I was pregnant … It was horrible, I dread being pregnant again … Other than feeling sick, everything else was fine really … I sort of enjoyed it towards the end. Participant 124 (unplanned caesarean)

_Worry_ - A quarter of the participants specifically referred to feeling worry during the pregnancy, with the worry specifically about the health of their baby throughout pregnancy, and only completely relieved by the birth of their healthy baby. These participants discussed being initially comforted by scans of the foetus while pregnant, but later reverting to their original worry as wondered whether the scan may have missed something. Four of these participants had experienced previous complications or difficulties in their pregnancy, which appeared to exacerbate the worry about the health of their baby.

I was worried the whole time, you know, I would keep waking up in the middle of the night and I’m thinking … is she still moving, is she still alive … what if she’s got like something really wrong with her … right until before she was born I was just always worrying. Participant 108 (planned caesarean)

_'Natural best'_ - Three quarters of the participant's described a perception that vaginal births were generally viewed as superior to caesarean births. This was implied by most participants to be the dominant social attitude. As such, these participants gave the impression that society viewed vaginal birth as the _better_ birth option, while caesarean birth was somehow not a _good_ birth. This also appeared to be perceived as a sense of social pressure to complete a vaginal, rather than caesarean, birth.
It’s just such a perception that it’s a bad thing to have a caesarean, it’s just like assumed that it is negative and bad and there is no sort of, it doesn’t seem to be treated even-handedly … I think so much pressure, social pressure around, you know, umm, you must try and do this naturally and it’s better for you and it’s better for the baby.

Participant 108 (planned caesarean)

Those participants who perceived a sense of social pressure to have a vaginal birth also suggested there was some sense of a rite of passage or legitimacy that was attached to vaginal birth. They perceived that caesarean birth was viewed as something of a short-cut, and as a way to avoid the challenging rite of passage of vaginal birth.

Maybe it’s a social thing where you kind of are made to feel that if you don’t have a baby by naturally, that is vaginally, you’re not really, you haven’t really done it you know.

Participant 112 (planned caesarean)

This perception of the general inferiority of caesarean was also associated with the way participant’s perceived information was presented in antenatal (childbirth education) classes. Half of the participants described antenatal courses as portraying caesarean deliveries as something to be avoided, rather than discussed as a possible alternative to vaginal birth. This opinion was shared by participants who anticipated both caesarean and vaginal birth, suggesting their perception of how of childbirth information was delivered was not dependent on their own anticipated birth type.

It is run by a midwife so say the natural way is the way ... that the natural way is the way to go. And they tried to umm, yeah, talk about a caesarean but ... something to be avoided at all costs, yeah.

Participant 109 (unplanned caesarean)

Therefore, in summary, pregnancy was typically viewed as both a positive experience but also as a physical burden, with worry about the baby prominent for some of the participants. The majority perceived social pressure to achieve vaginal birth, with the sense this would somehow correctly fulfil the rite of passage of birth.
Preferences and Expectations during Pregnancy

Unplanned Caesareans

Of the sixteen participants who planned to have a vaginal birth throughout the course of their pregnancy, fifteen also described this as their preference over caesarean birth. Approximately one third of these participants expressed a particularly strong preference, the majority held it as their main preference, while several were somewhat ambivalent between preferring vaginal or caesarean birth. In addition to their preferences, expectations varied among these participants who planned to have a vaginal birth. Approximately two thirds said they never expected caesarean birth would happen to them, while the remaining participants said they were aware of the possibility they could experience caesarean birth, with this awareness possibly lowering their expectation for vaginal birth. Therefore, although theoretically each of these sixteen participants planned for a vaginal birth, there was a varying degree of preference and expectation regarding this.

The themes that were identified from this section of the interviews were: Preferences - Natural birth is better; and Expectations - Caesarean won’t happen to me. A number of sub-themes were found under each of these domains, and they are described below to demonstrate how the preferences and expectations of the participants were reinforced. These themes are also shown diagrammatically in Figure 2.

Figure 2: Themes regarding Preferences and Expectations held during pregnancy
Themes

Preferences: Natural is better - As discussed earlier, participants differentiated between the preferences they perceived others held for vaginal birth (social attitudes) and their own individual preferences. When discussing individual preferences, all but one of the participants who anticipated a vaginal birth indicated a preference for vaginal birth. Approximately one third of these participants were particularly emphatic, describing clear preferences for vaginal birth.

The whole birthing process had been so so so important to me that I really wanted a natural birth. Participant 122 (unplanned caesarean)

Only one of the participants who expected a vaginal birth said she would prefer a caesarean. This participant also had not enjoyed her pregnancy due to symptoms of morning sickness, and she explained her reason for wanting a caesarean birth was because she wanted to avoid the pain of childbirth. However, she expected and planned to have a vaginal birth as she did not believe she held sufficient reason to be allowed to choose a caesarean birth.

I think I’m one of these women who, if I had had a choice, I probably would have like, chosen to have a caesarean from day one of the pregnancy. But because you can’t do that, I just went with the flow. Participant 124 (unplanned caesarean)

Although the majority of participants perceived vaginal birth as the socially preferred birth method, this was not conceptualised as the ‘easy’ option. The participants described informal discussions with peers during which vaginal births were described as painful or difficult, and half of the participants of this research indicated they found the prospect of vaginal birth daunting or intimidating.

So many people had said, oh god it’s awful … I think I was quite scared that the pain was going to be so intense that my body wouldn’t be able to cope with it. Participant 105 (unplanned caesarean)
Perhaps as a strategy to mediate any feelings of intimidation for vaginal birth, more than half of the participant’s spoke of their confidence they would get through the birth process, and several of the participants appeared to hold birth plans that were particularly positive. Although these were acknowledged as being somewhat idealistic, these participants gave the impression they believed their birth would not be as difficult as the stories they had heard.

I think I had quite a romantic view of it [laughter] I think I thought I would just quietly go into labour at home and I would have the baby without any drugs. I was really determined to do that and that it would be really painful but that would be fine.
Participant 114 (unplanned caesarean)

*Expectation: Caesarean won’t happen to me* - Approximately one quarter of all births in NZ are through caesarean delivery, and one quarter of the participants who expected a vaginal birth acknowledged this as a possibility for themselves, although did not see this as very likely. The remainder of the participants who expected a vaginal birth never appeared to consider caesarean birth as a possibility for their impending birth.

When I was thinking about giving birth and all that, really, I mean they went through it [caesarean] at antenatal class, but I honestly didn’t think I would need it. To be honest, I didn’t pay that much attention to that part of it. Participant 120 (unplanned caesarean)

A variety of evidence was used to support this expectation for vaginal birth, including several participants who compared themselves with people they knew who had successful vaginal births. These participants implied a belief they would have a similar experience to that of friends and family, with a sense of, 'if they can, I can'.

Yeah, I thought it was all going to be pretty easy and she was going to pop out, because my mother had had eight. I’ve got six sisters and they’d all had really easy births, it never ever occurred to me anything would go wrong or that I would even need a caesarean.
Participant 114 (unplanned caesarean)
I had a sister-in-law who had a baby, and umm, she hated, hated doctors but went and had this baby in the water, no pain relief, nothing; so I thought, man, if she can do it I can definitely do it, I was like, I play sport and I do all that sort of stuff.

Participant 117 (unplanned caesarean)

As noted, a quarter of participants anticipating a vaginal birth spoke of the possibility they could experience caesarean delivery, commenting on the rising proportion of caesarean births and experiences of friends who had experienced caesarean birth. In addition, several specifically referred to their use of a specialist or obstetrician, which they implied may increase their likelihood of a caesarean.

And I don’t know if it is because specialists are into intervention or monitoring or whatever, I don’t know, but I know that they are into interventions but, what is the harm?

Participant 109 (unplanned caesarean)

However, even when a proportion of the participants acknowledged caesarean as a possibility, it did not appear to be the primary expectation held by any of the participants who did not plan a caesarean birth. Instead, they appeared to acknowledge the possibility without actually changing their own expectations.

I don’t know, looking back. I just, I sort of always knew it was on the cards, that there could be a caesarean, but I somehow just thought that I’d be fine … no I sort of didn’t really think I’d have a caesarean.

Participant 111 (unplanned caesarean)

Planned Caesareans

As noted previously, sixteen of the participants learned they would be experiencing caesarean birth, with awareness coming at various stages of their pregnancy. Of these, approximately one third knew they would be having a caesarean birth from the outset of their pregnancy and described this as their preference, primarily due to previous birth experiences or other
medical reasons. Three participants learned their babies were breech over the course of their pregnancy and, after medical advisement and in line with NZMOH guidelines, agreed to caesarean due to the rationale of this being a safer option for their breech presentation. Two of these three participants appeared somewhat ambivalent about vaginal birth, with the third stating vaginal birth definitely would have been her preference.

Three other participants developed pre-eclampsia at varying stages of pregnancy, and in addition to feeling unwell, all agreed with the rationale of caesarean birth being a safer option, with only one expressing a particular preference for vaginal birth. The remaining participants planned to undergo caesarean births over the course of their pregnancy for a variety of reasons. Of these, three had experienced previous caesarean births and held mixed expectations and preferences regarding their impending birth. The remaining two participants were both ambivalent about vaginal birth, referring to their age at some stage of the interview, being two of the older participants in the study.

When the participants who planned to have a caesarean were asked to recall ideas they had held about childbirth during their pregnancy, themes clearly diverged from those of participants anticipating a vaginal birth. These participants expected a caesarean birth (Expectations - I am going to have a caesarean), although some acknowledged initial surprise when they realised they would not be having a vaginal birth. In addition to this, the theme of caesarean birth being the preferred option was also identified (I prefer a caesarean). A number of rationales were proposed to support this theme (Caesarean birth is safer; Means to an end; I had no choice) and these are discussed in detail below, and presented visually in Figure 3.
Figure 3: Themes regarding Planned Caesareans – Expectations, Preferences and Justifications

**Themes**

**Expectations** – Although all sixteen participants with planned caesareans learned they would have a caesarean at some point in their pregnancy, several mentioned their initial feelings of surprise that they would not have a vaginal birth. This reaction appeared most commonly among the quarter of participants who had their caesarean planned for breech presentations, or following the development of pre-eclampsia later in pregnancy.

So that was a bit of a shock, so I had to sort of come to terms with that I wasn’t going to have a natural birth, which I wanted a water birth and all that sort of stuff, you know, so I suppose I came to terms knowing that I was having a caesarean.
Participant 128 (planned caesarean)

Several of the participants described originally holding the notion they would successfully experience vaginal birth due to their physical size or good health. None of the participants in this research were significantly physically large or small, but it appeared several participants held an association between maternal size and vaginal birth.
But to be honest, I kind of felt like I’ve got big hips (laughter) I really did, I just kind of thought no I think I can do this you know, I kind of I expected to have a natural birth. Participant 110 (planned caesarean)

And as I said, being a big girl with good hips I thought I was just going to push it out no problems. Participant 131 (planned caesarean)

Similarly, several of the participants appeared to hold a belief that vaginal birth was associated with physical health or robustness, and therefore caesarean births were somehow associated with limitations of some kind. Therefore, as they themselves were in good health, they would not need a caesarean.

I didn’t think I’d need to have a caesarean. Umm, but that is based purely on the fact that I didn’t see that there was anything wrong with me. Participant 112 (planned caesarean)

Just over half of the participants who anticipated a caesarean discussed their belief that the surgery and subsequent recovery would be a difficult procedure. This is similar to those anticipating vaginal birth expecting it to be a difficult process. In addition to referring to the stresses of surgery, many of the participants referred to anecdotal reports of recovery from caesarean as being particularly difficult and painful.

In the lead up to it everyone telling you, you know, oh poor you, oh poor you, it’s going to be so awful, oh god, who’d have a caesarean section, oh that can be awful, so many people. Participant 108 (planned caesarean)

Preferences – I prefer a caesarean: It was complex to identify the preferences that were held during pregnancy by the participants who planned to have caesarean births, as their preferences were impacted by the individual reasons for their scheduled caesareans. One third to the participants who planned caesarean birth appeared to be relatively neutral regarding their preferred birth method, while approximately one third of these participants held clear preferences for caesarean birth.
And I decided that I wouldn’t, if I were to have another child I couldn’t go through that [vaginal birth] again, so I ended up meeting with my gynaecologist who is my obstetrician and saying to her that I could only have another baby if I was delivered by caesarean. Participant 106 (planned caesarean)

The remaining third of the participants who planned a caesarean birth were somewhat more ambivalent regarding their preferences. These participants agreed with the medical rationale or necessity for caesarean birth, but had somewhat more mixed attitudes regarding their preferences for the birth.

Yeah I don’t know, I’ve still got mixed feelings about natural birth ...yeah, about whether I could cope with it or not. Participant 115 (planned caesarean)

In addition to discussing these preferences, approximately two thirds of the participants who planned a caesarean birth did not make any reference throughout the interview to any regret or disappointment at not experiencing a vaginal birth. The remaining third of participants who experienced a planned caesarean birth made some kind of reference to regret or disappointment regarding their caesarean, perhaps indicating some degree of inclination for vaginal birth.

I spent a lot of time thinking about having a natural birth and I quite wanted to have, you know, to do that, in water as much as possible, all those sorts of things, and I hadn’t, I don’t know, thought through the whole [caesarean] process. I had thought through the whole process of a natural birth ... Because I suppose it logical ... I really wanted it to be a natural birth. Participant 113 (planned caesarean)

However, even for these participants who implied some kind of disappointment in not experiencing vaginal birth, they did not express regret regarding the actual decision for the caesarean birth. Instead, each of these participants referred to the rational or justification for the caesarean, even when expressing some disappointment.

I mean, I think that the idea of going into labour, it would have been nice, and I think some days I’m a little bit regretful that I didn’t get to it, but at the end of the day, you know, things can go wrong with labours too ... so it doesn’t really bug me that it didn’t happen. Participant 107 (planned caesarean)
Of the 16 participants who planned caesarean births, a quarter were offered the tentative possibility to attempt vaginal birth by their specialist. This occurred towards the end of straightforward pregnancies, or as medical concerns reduced (e.g., fibroids no longer blocking the cervix). Each of these women declined the opportunity of a ‘trial of labour’ and referred to the difficulty of letting go of their original safety concerns, as well their reconciliation and resulting preference for a caesarean birth.

[the specialist offered to trial labour] … so then I sort of burst into tears about all about that, because I thought, I’ve just psyched myself up to having a caesarean, now you are telling me I’m having, to have a natural birth … and I was sort of told that I could possibly die if I had a natural childbirth, and now you’re telling me I could do it, so, you know, I sort of had all those sort of conflicting issues … and I said, oh I don’t really want to risk it. I’d rather go for a caesarean, because that’s what I’d got my head round. Participant 128 (planned caesarean)

*Justification* - Over the course of the interviews, all of the participants who had planned caesareans referred to at least one or more of the three rationale's identified through the data analysis process: Caesarean birth is safer; Means to an end; No choice. These appeared to be used to justify the decision for a caesarean, and are detailed below.

*Caesarean birth is safer, Vaginal birth is dangerous* - More than half of the participants who had a planned caesarean birth referred to this as the “safest option”. Caesarean birth was described as being safer for the participant’s themselves, but more often in relation to the safety and health of the baby. Some of the participants implied this sense of dangerousness with vaginal births by referring to stories of vaginal births going wrong, implying an inherent level of risk associated with this birth method.

You hear all the horror stories about, you know, babies and when they are naturally born and things like that, and I mean it’s horror stories both ways, but I kind of knew as well that it [caesarean] was very safe and efficient for her. Participant 110 (planned caesarean)
In addition to the sense of danger associated with vaginal birth, the participants who referred to caesareans births as safer than vaginal births spoke of caesareans as an advancement of birth technology. Several referred specifically to the idea that they, or their baby, would have died without the surgical intervention.

I guess I feel that I wouldn’t have ever been able to give birth to any of them and just pleased I wasn’t born a hundred years ago, and being alive. And my children are alive, so I guess I’m quite pleased about that. Participant 119 (planned caesarean)

The participants appeared to demonstrate a shift from the perception of vaginal birth as painful and ideal, to vaginal birth as painful and potentially dangerous. None of the participants referred to any increased risks with caesarean birth, for themselves or for their babies, although current practice requires that all participants should have been informed of the potential risks and complications of caesarean delivery.

Means to an end – In contrast to the frequently detailed birth plans created by participants who anticipated a vaginal birth, participants who knew they would be having a caesarean birth varied in their development of comprehensive birth plans. More than two thirds of participants who planned to have a caesarean emphasised the importance of a healthy baby and self over the process of birth itself. This appeared to imply that the process or method of birth was not inherently important, with the implication that caesarean birth was simply a means to an end (i.e., healthy baby), and somewhat irrelevant beyond that.

I was also thinking there’s the end, that’s the finish line, that’s where I was trying to get to. So it more about getting to the end if you like, rather than by then it was more about getting to the end rather then whether it was a caesarean or a labour, it didn’t worry me. Participant 107 (planned caesarean)

I had no choice – Two thirds of participants who underwent planned caesareans emphasized that the decision to have a caesarean was not a choice in the usual sense of the word. These
participants emphasised the role of the specialist and their recommendation for caesarean birth as the only viable option. Therefore, although these participants agreed to undergo a caesarean, they did not perceive it as a matter of simply choosing between two birth methods, as they did not believe vaginal birth was a viable option.

As it was, it wasn’t an option [for vaginal birth] ...So yeah, I felt there was never an option that we weren’t going to end up in this path [caesarean birth]. And I’m glad there was no ambiguity. Participant 113 (planned caesarean)

More than one third of participants who had planned caesareans specifically discussed the term “elective” as inaccurate and inappropriate to define their experience. These participants were emphatic in their aversion to the word “elective”, with the belief it implied a degree of choice that was unfounded and not part of their experience.

We are very touchy about being told it’s an elective caesarean, because it’s not elective really, we don’t really get a lot of choice about it. And there is such a stigma attached to elective caesareans now. The minute you say elective I mean, just the word itself, you say elective, it sounds like there’s a choice. Participant 107 (planned caesarean)

I suppose the other thing, and the wording, actually to say its an elective caesarean when you have a breech birth, a breech presentation, is, I think it's, it’s not elective at all. It makes it sound like it’s your choice to get a caesarean. Participant 113 (planned caesarean)

The concept of elective caesareans was also raised by participants who had emergency caesareans, although this was typically used in the form of a different justification, with elective caesareans contrasted with their own "non-elective" caesarean birth. This is discussed later in the Results section in relation to reactions to caesarean birth.

Summary

To summarise, this section outlined the themes identified by participants regarding ideas they held during pregnancy. Themes were identified suggesting pregnancy was a positive experience, even when it was physically uncomfortable (Ambivalence); participant's were nervous throughout
pregnancy (Worry); and that participant's typically believed society viewed vaginal birth as preferable to caesarean ('Natural is best'). The participants who expected to have vaginal births generated themes regarding their preferences (Natural birth is better), even when they believed it would be painful and difficult; and themes regarding their expectations that they would successfully experience vaginal birth (Caesarean won’t happen to me). These participants discussed idealistic birth plans and their confidence in their own physical attributes as bolstering their genuine belief they would experience a vaginal birth.

The participants who knew they would be having a caesarean developed alternative themes regarding their expectations (I am going to have a caesarean) and preferences (I prefer a caesarean). Although some of these participants referred to an initial surprise when they learned they would need a caesarean, as well as trepidation regarding the recovery, they justified the decision for their planned caesarean (Caesarean is safer; I had no choice; Means to an end). Although some expressed disappointment at having a caesarean delivery, none who were offered the option of a vaginal delivery chose to change their mind. Finally, a third of participants who experienced planned caesarean’s reacted against the use of the word ‘elective’, believing it implied a sense of choice that did not accurately describe their experience.

**Labour**

Sixteen of the participants had emergency caesarean deliveries, which took place after the commencement of labour. All of these participants began their labour anticipating a vaginal birth, so at some point each had the realisation that the outcome would not be what they expected or prepared in their birth plan. A number of themes were identified around this divergence of preferences and expectations with their actual experience. The first stage of the labour either approximately matched expectations or began to deviate (Labour begins); the labour clearly diverged from the birth plan.
once a caesarean delivery was indicated (*Preferences and Expectations challenged*); the participants let go of their initial preferences and expectations (*Transition*); and then began to react to their experience (*Reaction*). These themes are discussed in greater detail in the following section and are detailed below in Figure 4.

*Figure 4: Themes regarding Labour by participants who experienced unplanned caesareans*

**Themes**

*Labour begins* - Six of the participants commenced their labour spontaneously, although five of these later had some kind of augmentation of their labour. In addition to these participants reporting a sense of relief that the labour process had begun, they also described reactions that ranged from excitement to fear regarding the prospect of labour.

[How did you feel when your waters broke?] Petrified. I thought oh shit, this is really going happen now. Participant 114 (unplanned caesarean)

There was also varying reactions by the ten participants who were induced in order to begin their labour. The two participants who were overdue welcomed the opportunity to end their pregnancy and start labour, while those who were induced in response to concerns for the baby frequently referred to the sense that it may not be optimal timing and could be the first indicator of the labour not going to plan. Several implied that induction was part of a process that needed to be
followed, but did not appear to hold a great deal of faith in the process, suggesting caesarean was the likely result.

We were induced on the day, he obviously wasn’t ready to come out that day anyway as he hadn’t dropped and sat really really high, umm, so obviously he hadn’t engaged, umm so the chances of him engaging seemed slim. Participant 109 (unplanned caesarean)

Therefore, induction was perceived as commencing labour by some, while others saw it as the first indicator that perhaps their labour would not match their expectations. In addition to the ten women who were originally induced, five of the six participants who initially went into spontaneous labour also required medication to progress their progress. Almost half of those participants specifically referred to their disappointment regarding their lack of progress during the labour.

I was so, oh my god, at times I thought I took four hours to get 1 centimetre, and if it’s four hours to get 1 centimetre that’s going to be like 40 hours labour! Participant 114 (unplanned caesarean)

In addition to concerns regarding progress, several participants expressed surprise at how painful the labour was. Although the majority of participants had reported hearing stories throughout pregnancy regarding how painful labour, as discussed earlier, these did not always appear to be integrated into expectations for the participants own anticipated experience. Perhaps this also reflected the idealistic nature of some of their birth plans held during pregnancy.

So yeah, they got worse and worse and then I thought I’d have some pethadine you know as opposed to my birth plan of not having anything, but they were so painful. Participant 117 (unplanned caesarean)

Therefore, the beginning of the labour process contrasted to the expectations that were held by many of the participants, including the use of induction methods to both start and augment labour for almost all participants planning to have a vaginal birth. However, in spite of this early
intervention, at the early stages of labour most of the participants were still anticipating a vaginal birth.

**Challenges: Things start to go wrong.** For all of the participants, at some point during labour the situation necessitated the decision be made to undergo caesarean delivery. For approximately two thirds of the participants this was a relatively gradual process, as it slowly became obvious the labour was not progressing well.

So they mentioned the possibility of a caesarean later on … but it was good because she had warned me a little while before, because we hadn’t actually made that decision but we got to the point where we could see that it was on the cards, but we were hoping that things would sort out before that happened. But I guess that it allowed me, in my own mind, to get my own head around it a wee bit. … and I think, even though it was hard to hear, I think it was a good thing as it did give me a chance to mull it over in my own mind so when she said, this is what we need to do now, it was ok. Participant 123 (unplanned caesarean)

The lack of immediate urgency allowed time to think about options and the opportunity for discussion with partners or others. For these participants, most described the decision-making process as part of a collaborative discussion.

[described being asked] ...and how do you feel, what do you want us to do, and it was everything I was talked – that’s not right, they confided in everything and asked me what I thought as well. Participant 103 (unplanned caesarean)

Several of the participants described their decision-making process as collaborative, but then outlined circumstances which suggested that caesarean was not one of the choices available, but usually the only option. However, these participants were given the option to delay the surgery and continue with labour for a set period of time, and they seemed to perceive this as participating in a collaborative decision-making process.

So it was all kind of like obstructed labour was happening. So he said, you can keep going for another hour or so if you like, but I really don’t think you can get there. . Participant 111 (unplanned caesarean)
In contrast to this gradual process, the decision to have a caesarean was made more abruptly for approximately a third of the participants. This situation typically occurred when the medical staff became concerned regarding the health of the baby, frequently via heart monitoring, or were concerned regarding the health of the participant. In these situations, the decision for caesarean was usually made without prolonged discussion, and the time between the decision for caesarean and actual surgery was usually short.

So P said oh we need to whip her out... so then with that all of a sudden there was all this rushing around and people preparing things at my end and I had forms to sign and people from the theatre coming up to brief me on this, that and the other, and they would go out, and then P would rush off downstairs to get all gowned up for him and they topped my epidural up and then went down to the operating theatre. Participant 122 (unplanned caesarean)

For these participants, the decision for caesarean surgery was a medical decision made by medical staff, and collaboration in the decision-making process was not particularly prominent. However, none of these participants commented negatively on this lack of collaboration, even when they had no input into the decision for caesarean other than giving consent. This perhaps suggests a confidence in medical staff, with collaboration not necessary as part of the decision-making process for all of the participants.

No. I didn’t make the decision. But I mean to me, that’s what I’m paying him for. You know I paid him three and a half thousand for his professional, I don’t know about it, I was completely happy to defer to his judgement. Participant 114 (unplanned caesarean)

Transition (Letting go of expectations and preferences). As discussed, at some point in their labour, each of these participants learned that their labour would not match their preferences and expectations for vaginal delivery of their baby. At this point of the labour, the majority of participants described their sense of trust in the medical team, with a sense of "the experts in
charge”. This faith in medical staff was noted by more than three quarters of the participants undergoing an emergency caesarean.

I just had such a trust in the people that were looking after me ... I knew the specialist and the midwife quite well, I kind of know how they work and I felt he’s not going to rush in and do anything unnecessarily, and I’m in safe hands. Participant 111 (unplanned caesarean)

The theme of having experts in charge re-occurred a number of times throughout the interviews, as well as across the participants, and appeared to distil a sense of security or increased confidence to the participants. In particular, this appeared to impact the amount of anxiety or worry the participants had during their labour for their baby or themselves, as although several participants acknowledged worry for safety of their baby or themselves, no participant spontaneously described anxiety as a prominent aspect of their labour experience.

[Were you worried?] No, I wasn’t really, which kind of surprises me, now when you ask that question. While I thought I hope she is alright, I think I had complete faith in him [obstetrician] and yeah I don’t know, no because I knew her heart was still beating, was dropping and sort of not quite right and I was thinking that she was going to get out. But no, I had faith in the midwife as well ... Participant 114 (unplanned caesarean).

This relative absence of anxiety is somewhat incongruous considering that the caesarean was taking place because of some kind of problem in the labour process. It is possible anxiety was reduced because the participants perceived they were no longer responsible for the labour process. When asked about their feelings of control, three-quarters of the participants discussed the sense that they had handed over control to the experts. These participants stated that they did not feel out of control, but instead that the situation was no longer under their own control or responsibility. These participants gave the impression that their labour, birth, and decisions around this were being taken care of by the experts.

I did feel like I was passing it [control] onto someone else. I had control but I was relinquishing it, sort of thing. Participant 105 (unplanned caesarean)
I felt very comfortable with it, and that I was in good hands and that it was all out of my control … they were, it was just like a well oiled machine that was working well.
Participant 109 (unplanned caesarean)

Reactions – As described, the decision for caesarean was made at varying points of the labour process, with more than half of the participants specifically described experiencing a sense of relief when the decision for caesarean was made. This seemed to be relief that the labour would be over, but also appeared to be a sense of relief that the participants could now pass some of the primary responsibility for the birth of their baby to others.

I think I probably, umm, when they said, when we actually finally made the decision to have a caesarean, I umm did have a few tears at that point but I think that was more of a release umm, and a relief that it was a decision that we had made.
Participant 104 (unplanned caesarean)

I guess once I’d made the decision …I actually felt quite relieved, because I could stop and see what someone else said. Basically, so handed over to someone else to make the decision of what to do next I think. Participant 105 (unplanned caesarean)

In addition to describing a sense of relief, almost half of the participants who had anticipated a vaginal birth emphasised the importance of having a healthy baby and minimised the significance of the birth method. Therefore, as the labour diverged from the original birth plans, these birth plans were discarded and the emphasis shifted from the labour to the end result.

I just want S delivered safely, and me to be safe as well. I think they were both relieved at that point. Participant 104 (unplanned caesarean)

By that point I was sort of yeah okay, just do whatever, I didn’t want a distressed baby, I just want what is best for the baby’s health. Participant 120 (unplanned caesarean)

Therefore, although these participants had previously indicated they both preferred and expected to have a vaginal birth, it seems they may already have commenced a rationalisation
process of their caesarean birth. This particular rationale, highlighting the health of the baby as the only important factor, was discussed previously by participants who knew they would have a caesarean (Means to an end).

Summary

In summary, for those undergoing emergency caesarean, labour was the point during which they realised that the birth of their baby would not match the expectations and preferences they had held throughout their pregnancy. Expectations and preferences were challenged at varying points from the commencement of labour (Labour begins); due to significant issues or problems that arose during the labour (Things go wrong); acceptance their labour would not culminate with the anticipated vaginal labour (Transition - Letting go of expectations and preferences); and reactions to this decision (Reaction). Participants often referred to the importance of a healthy baby rather than the delivery method at this point, echoing the sentiments of participants who had planned caesareans. Labour was not discussed for those participants who planned caesarean births, as labour did not occur for those participants.

Caesarean Section Delivery

Regardless of whether they experienced labour, all of the thirty-two participants experienced caesarean birth, although four had this under general anaesthetic and were unconscious for the actual surgery. When discussing the caesarean delivery almost all participants once again referred to the expertise of the medical team, with the sense this gave reassurance and confidence in the process. One third of all the participants of this research described the operation itself in both positive and negative terms, with ambivalence more common for those with unplanned caesareans which may, in part, reflect the lack of time to adjust to the idea of a caesarean birth before the surgery took place. Differences also were identified between planned and unplanned caesareans when positive reactions
were examined, as less than one fifth of participants who had emergency experiences discussed their caesarean surgery in wholly positive terms compared to just over half of those who had scheduled caesarean births. Interestingly, similarly small proportions (approximately one fifth) of each group described their surgery in negative terms.

When describing their first interaction with their baby, half of all the participants once again appeared somewhat ambivalent or neutral, describing the experience in neither positive or negative terms. However, a larger proportion of the participants who had unplanned caesareans (approximately one third of that group) were more likely to comment negatively on this, compared with half of this for the group of participants who experienced planned caesareans.

The majority of all participants referred to the caesarean birth as being a somewhat surreal experience, perhaps reflecting the conflict of expectations and their actual experience, and part of a transition process. These themes are discussed in more detail below, and presented diagramatically in Figure 5.

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**Figure 5: Themes regarding the Caesarean Birth for all participants**
Themes

Experts in charge – More than a quarter of the participants commented on the high number of medical personnel in the operating theatre. Some were surprised at the size of the surgical team, perhaps reflecting the impression that caesarean surgery is somehow different from other abdominal surgery, while others were expecting the number of medical staff having been informed about this during antenatal classes.

Then when you go in there is so many people in the operating theatre and if you weren’t told in advance there’s going to be this one, this one, you’d think oh my god it’s like a cast of thousands, you know. Participant 108 (planned caesarean)

Whether informed on the number of medical staff or not, most of the participant’s who commented on this found the high number reassuring rather than intimidating. They often referred to the concept of the staff working as an organised team, which appeared to add a sense of organisation or structure to the process.

I was quite happy in the theatre because I couldn’t believe this swarm of people, you know, you had this whole machine operating on you, this machine of people, and everyone was doing something, everyone had a role, and you were completely in their care. I felt completely relaxed and happy about that. I thought, if I’ve got twelve people buzzing around me, then I’m fine. Participant 109 (unplanned caesarean)

Everyone had a, you know, everyone had a part, everyone was kind of buzzing around you, doing this and doing that, and you were just lying there, a bit out of it. Participant 112 (planned caesarean)

More than half of the participants commented on the confidence they had in the medical team, and how much this impacted their actual experience, with the theme of 'experts' common through the majority of the interviews. Participant’s referred to their specialist, midwife and other staff in positive terms, with almost a quarter of the participants specifically referring to the
anaesthetist as particularly influential on their experience, particularly with regards to providing them with a commentary through the operation.

I didn’t realise the anaesthetist had such a big role in my life … talking … epidural …like as an important role as the obstetrician. Participant 114 (unplanned caesarean)

Only one participant did not find this to be the case, feeling isolated throughout the caesarean operation. Although her caesarean was planned due to medical complications from her previous vaginal birth, she described the operation as clinical and sterile, perhaps in comparison to the non-surgical environment of her previous vaginal birth.

I mean, no-one really talks to you. If it wasn’t for the anaesthetist occasionally saying something comforting to you, you just feel like just a body on a bed. Participant 102 (planned caesarean)

Half of the participants commented on negative aspects of the surgical experience, with symptoms such as vomiting and nausea both during and after the surgery. Most of the negative comments, however, were regarding the spinal or epidural anaesthetic, used by 28 of the 32 participants. This was usually experienced as unpleasant and painful, and frequently accompanied by the participants experiencing significant shaking and trembling. However, a negative experience with the anaesthetic did not necessarily lead to the women perceiving their caesarean negatively, as is demonstrated below by contrasting comments made by two of the participants.

I think the worst part about the whole operation was the epidural, of that going in. I found that quite nerve racking and I was really nervous and quite sort of like, ohh, and didn’t feel great and it was pretty horrible

... [Positive about the birth?] ... Yeah it was great. I really did have a good experience ... No, I mean from the whole experience, it was all really good. Participant 110 (planned caesarean)
So I was lying on the table and the epidural comes up to your nipples so you feel like you can’t breathe, and trying to vomit while shaking and not being able to breathe was a bit scary...

[And when you look back on the birth now?] ...Oh I think it was extremely positive, absolutely ... really it was fine, I really enjoyed the whole thing.

Participant 104 (unplanned caesarean)

Four of the participants experienced general anaesthetic and were unconscious for the birth. These were each unplanned caesareans, reflecting the recommended practice of this anaesthetic being used primarily for emergency situations. Two participants did not appear to find general anaesthetic particularly detrimental to their experience, although were somewhat ambivalent and would still prefer to be conscious for any future deliveries.

Yeah, I’m glad we had the caesarean under a general as opposed to epidural ... caesarean birth under an epidural may not have been the most pleasant caesarean you could have... ... [And for another birth?] Yep, epidural. I would like to be there this time

Participant 109 (unplanned caesarean)

The other two participants who had general anaesthetic were not as ambivalent, describing their experience of general anaesthetic having a significantly negative impact on their experience. Both participants referred to a sense of disconnection from the birth and their baby, and a belief that their experience hadn't been the way a birth experience should be.

You see all these pictures, like my birth wasn’t anywhere in a book, you know, like you see all the pictures of them pulling the baby out, you know, of having him naturally and he’s there ... when I got him he was clean and wrapped up in a blanket, so it was, so I was kind of separated a little bit

Participant 117 (unplanned caesarean)

One of the participants found this particularly distressing, believing both she and her husband missed out on the optimal birth experience. She has found it difficult to move past the sense she had missed out on the birth, and tried to describe her sense of loss.
I woke up forty minutes later and I wasn’t pregnant. And I didn’t have a baby either ... We both found it really difficult afterwards having missed out but having not even seen him being born, both of us, it was almost like he could have somebody else’s baby, so as a result it was really difficult to bond. Participant 101 (unplanned caesarean)

Ambivalence- The actual caesarean experience differed across the participants due to the variance in the myriad of factors that impacted the surgery, such as sense of urgency, reaction to medication etc. Nevertheless, almost one third of participants displayed a sense of either ambivalence or indifference to the surgery, with slightly more of the participants who experienced unplanned caesareans expressing mixed views.

It was different, like, with the baby, when you usually have it, when you have a normal delivery, you give birth to the baby and it comes to you and you forget all that pain. But this time you’re obviously not in pain but you don’t feel anything.
Participant 129 (unplanned caesarean)

Interaction with the baby after the surgery also varied across participants, as some had contact with their baby in the operating theatre, while others had their first meaningful contact after they were moved through to recovery. Overall, however, half of all the participants did not appear to have a particularly strong positive or negative reaction to their first interaction, often describing a more neutral response.

And like as soon as they pulled her out they showed her to me and sort of brought her round so I could see her on the side, and umm she was crying as soon she came out, so to me she was quite bonny ...and umm so then they weighed her and checked her out and stuff, and she was fine. Participant 115 (planned caesarean)

Expectations and Preferences matched – More than half of the participants who underwent planned caesareans discussed their birth experience as matching their expectations and preferences for the birth. These participants described positive experiences, and frequently referred to the
importance of the positive interactions with medical staff having a significant impact on their experience.

Everyone seemed to be working really hard to make this like the best possible experience we were going to get. So, it just seemed to work that way. We had just a lovely time. Participant 107 (planned caesarean)

Even though it wasn’t, you know, the clearest of experiences, it was a joyous experience. It was just so happy. Participant 106 (planned caesarean)

A third of participants who had unexpected caesareans also made positive comments about the surgery, although often as part of a more ambivalent response. Several of these particular participants had earlier acknowledged caesarean delivery as a possible outcome of labour, and although they didn't really think it would occur for them, caesarean may not have been completely unexpected. In addition, two of these participants had medical vocational backgrounds and therefore some familiarity with medical procedures, perhaps minimising a negative response to surgery.

I mean it's always different being on the receiving end of it, but I also knew what they were doing. Like, I knew what drug was there, and what the blood pressure cuff was for ... I’ve been in that situation when I’ve had to do that to a patient, I knew just to relax. Participant 104 (unplanned caesarean)

As mentioned, although half of the participants appeared relatively neutral regarding their first contact with their baby, approximately a quarter of participants described their first contact with their baby following the surgery as a positive experience. Once again, the majority of those with positive recollections of this initial contact had experienced a planned caesarean delivery.

The anaesthetist took some photo for us and everything, and yeah, my husband then went over while they checked her and then he brought her round all wrapped up and so yeah, I mean it was we actually had quite a nice experience. Participant 108 (planned caesarean)
Several participants described a delay in the initial contact with their baby following their caesarean birth, and as differing from what would have occurred following a vaginal birth. However, although none of the participant's described this as their preference, it was also not particularly emphasised by participants who experienced planned caesareans, as seemed to be an expected part of the caesarean process.

I think it’s the only downfall with a C section is you haven’t got the ability to be able to hold and cuddle and things like that. Participant 102 (planned caesarean)

It was just great to see him out, really great, I definitely, at that stage the whole caesarean thing had taken the gloss off the “here’s the baby” and especially because he didn’t come anywhere near me, it’s kind of like “here’s the baby” but all at a distance. Participant 113 (planned caesarean)

*Expectations and Preferences not matched* – As discussed, although the surgical experience varied for each of the participants, the 16 participants who learned they would have a caesarean while in labour generally discussed their surgery less positively than those who experienced planned caesarean deliveries. Almost a third of these participants with unplanned caesareans described the surgery in negative terms, emphasising their dislike of the surgical delivery.

I thought oh I can’t think about it, but I just closed my eyes and I just couldn’t wait for it to be over it was awful. Participant 111 (unplanned caesarean)

A quarter of the participants who had expected a vaginal birth specifically commented on physical sensations experienced during the caesarean surgery. These participants referred to the surgery as rougher than they would have imagined, with references to the sense of being pushed, or the baby tugged or pulled, and although most did not describe actual pain, many appeared to find the physical sensations discomfiting.
Yeah, it was quite uncomfortable. It was such an uncomfortable pushing down feeling and there was a pulling feeling as well, but it was horrible. I mean there wasn’t any pain but it did feel awful. Participant 105 (unplanned caesarean)

It was just that horrible, you know, they push on you to get the baby out and you feel like you can’t breathe and it was quite rough sort of pulling and poking. Participant 111 (unplanned caesarean)

Less than one third of participants who had scheduled caesareans also made some kind of negative description of their caesarean surgery. Once again, several of these participants also referred to the physical sensations of surgery. Although these participants had been aware they would have a caesarean, they did not appear to anticipate the physicality of the operation, perhaps an indication that information given prior to the birth may not necessarily equate with the actual experience.

And the caesarean itself was not what I expected at all, like even though people had told me that it was quite physical, it was much more physical than I thought it was going to be. Pulling and tugging. Participant 113 (planned caesarean)

A quarter of the participants who had planned to have a caesarean described the theatre environment as particularly sterile and clinical, which was not a particular feature in the narratives of participants who experienced unplanned caesareans. It could be that participants who experienced unplanned caesareans had less time to reflect on their surroundings, in the context of the more urgent nature of their surgery. In addition, the lack of urgency for planned caesareans may have allowed the clinical environment of the surgical procedure to be more obvious, as well as perhaps reflecting a conflict for these participants who had originally held a preference for a more natural vaginal delivery.

You know, it’s such a sterile environment, it’s so umm you know, it’s sort of stainless steel and it’s stark and it’s you know, the people around, there’s so many people in that room, it’s not, umm it’s not kind of what I always thought the environment that I would be in when I was giving birth. Participant 132 (planned caesarean)
As mentioned, although most participants were somewhat neutral regarding their first contact with their baby, a third of participants who experienced an emergency caesarean made some comment on the delay before contact with their baby, or that this contact was not what they had anticipated. This first interaction occurred in the minutes or hours following the birth, depending on the health of mother and baby.

I ended up seeing her at about, I don’t know, about half past 1 or something, but just seeing her, and I didn’t actually touch her till the next morning. Which was horrible.
Participant 105 (unplanned caesarean)

He just, he literally got whisked away, I don’t even know where he went ... looking back, ... I had sort of imagined, you know, they’d pull baby, the baby comes out and they put him on your chest and there is this great big bonding thing, yeah, umm and it, I sort of missed out on all of that, not that it really matters now, but looking back over it, I sort of, it would have been nice, I guess because I had that in my mind you know, because I wanted to hold him first and you know, just look at him ... I guess that would be the main thing I, I wouldn’t say I was disappointed, but didn’t, any of it, like what I had planned I really had wanted that, and it didn’t work out that way. Participant 120 (unplanned caesarean)

Transition - It felt so surreal - More than a quarter of the 32 participants made at least one reference to the caesarean birth being surreal or somehow unreal. Several of these participants experienced planned caesareans, but the majority experienced unplanned caesareans with more than one third of this group specifically referring to the sense of finding the situation surreal or unreal. These comments were in addition to any made about the sense of feeling over medicated or drugged, and several used this phrase to describe how they felt prior to the surgery and before receiving any anaesthetic medication.

They put me on the trolley and I’d almost giggling when I was walking, being rolled down the hall-way as I thought this isn’t really happening is it? This isn’t how it’s supposed to happen, it seemed quite surreal. Participant 131 (planned caesarean)
It is difficult to tease out the variables that may have contributed to this sense of finding the situation surreal, as medication; potential disparity between expectations and preferences with their actual birth; and the transition from a state of pregnancy to the state of motherhood with an infant may have all contributed to a sense of disconnection or finding the situation somewhat surreal. The surreal description most frequently occurred when discussing the birth itself, the period of recovery while in hospital, and interactions with the baby following birth, for participants who had unplanned caesareans.

The fact that I had had this baby and hadn’t even held her and it just didn’t feel real. You know, the whole process had not gone how I had wanted it to go. It felt quite unreal. It didn’t feel right. Participant 105 (unplanned caesarean)

The feeling I had, it was totally surreal, like holding this little baby in the crook of my left arm, did that just come out of me? Participant 122 (unplanned caesarean)

I had basically the first hold the following day … my husband brought her over and I sort of, it seemed so surreal, it was like, I don’t know, still like a dream, it wasn’t, it didn’t seem so real. Participant 103 (unplanned caesarean)

As noted, it is difficult to separate the elements that could impact this sense of disconnection or feeling surreal. In addition to the above comments, half of all the participants specifically referred to medication impacting their caesarean birth experience. These participants experienced planned and unplanned caesareans, with comments relating to the impression of feeling sedated, drugged or "out of it".

I didn’t feel like I knew much of what was going on, although I think they were terrific explaining it to me, but I was so out of it. Participant 105 (unplanned caesarean)

Half an hour later we were in theatre but I think it was the drugs because it’s all a bit blurry. Participant 123 (unplanned caesarean)
Comments regarding feeling influenced by medication were made in relation to the actual surgery, initial contact with the baby, and throughout the recovery period in hospital. In addition to impacting their initial experience, several referred to this sensation as affecting their creation of memories of the whole event.

The interesting thing I found about the C-section they left the catheter in my back and I had that for three days, so I was very drugged up ... Umm they let me keep that for three days and then they gave me morphine and something else to bring home with me... Yeah. So I had quite a lot. I felt like I was really drugged for about a week. I did sort of feel as though I was really quite out of it for quite a while. Participant 110 (planned caesarean)

Summary

To summarise the themes from this section regarding caesarean surgery itself, almost all of the 32 participants referred to the skill and size of the medical team. As well as being effective, there was the sense that this implied they were part of a coherent process, which appeared to give reassurance to those having an unplanned caesarean birth and reinforce the confidence for those having a planned caesarean (Experts in charge). When the expectations and preferences were met, most often for participants who planned to have a caesarean birth, the process was described in more positive terms (Expectations and Preferences matched). Those who found the operation a less positive experience may, in part, have been reflecting the conflict between their expectations and preferences with their actual experience (Expectations and Preferences not matched). The themes that were identified regarding a sense of unreality occurred for many of the participants, and this occurred for more than a third of participants who experienced unplanned caesareans. Although it is possible the effects of medication had some impact on this, it may also reflect the conflict of the contradiction between their imagined birth and their actual caesarean, and perhaps reflected a process of conflict and transition for at least some of the participants.
Reactions following the birth

An earlier section outlined the attitudes towards birth that the participants held while pregnant. This section reports the reactions that arose after the caesarean delivery, both for the participants themselves, as well as their perception of the reactions of others. Participants discussed the sense they were being judged by others (*Preferences and expectations of others*), and then typically refuted the specific aspect of judgement which they perceived, forming their own rationale for their experience (*Transition, Justification – New Rationale*). As this process reoccurred across the majority of interviews, participants appeared somewhat contradictory of one another. For example, participants who thought caesarean was viewed as the ‘easy’ option emphasised the difficulty of the birth or recovery. In contrast, participants who thought caesarean was viewed as the ‘hard’ option contradicted this and emphasised the ease of the caesarean or recovery. In addition to these specific refutations, the participants also offered a number of other justifications or rationales for their caesarean birth to refute perceived negative reactions of self and others (*Justifications – New Rationale*).

Some of the participants did not appear to perceive any particular reaction to their caesarean delivery, positive or negative. This (non) reaction was more common among participants who experienced an emergency caesarean, and is also discussed in more detail. In contrast, a small number of participants appeared to find it difficult to reconcile their actual birth experience with their previously held expectations and preferences (*Cognitive Dissonance*). Each of these themes is discussed in further detail below, and outlined in Figure 6.
Figure 6: Themes regarding reactions to the Caesarean Birth

Preferences & Expectations from others
- Caesarean the hard option
- Caesarean the easy option
- You missed out
- You did the wrong thing
- No one cares

Transition and Defence
- Caesarean not the easy option
- Caesarean not the hard option
- I didn’t miss out
- I didn’t do the wrong thing
- I don’t care

Justification & New Rationale
- I had no choice
- I laboured too
- Who cares, it is all about the baby

Cognitive Harmony or Dissonance
- Who cares
- I am so disappointed

Themes

Preferences and Expectations from others

As described earlier, three quarters of the 32 participants believe society views vaginal birth more favourably than caesarean birth. However, when discussing reactions to their actual caesarean birth, the participant's were more specific when describing their perception of the views of others, and a variety of additional themes were identified.

Others think caesarean hard – A quarter of the participants, with both planned and unplanned caesareans, believed others perceived caesarean birth as difficult. Although they implied the general sense of the whole caesarean process as fraught, several referred specifically to the
process of recovery from the operation. These participants often sensed pity in the responses of others to news of their caesarean birth.

But people, when they hear that you’ve had a caesarean they just assume that you’ve been through the most traumatic experience. So you keep getting all these text messages and cards and e-mails and stuff saying, oh you poor thing, and ‘hope you are alright’ and ‘how awful’, and it’s kind of like, oh actually it wasn’t that bad. Participant 124 (unplanned caesarean)

**Others think caesarean easy** - In contrast to the perception of caesarean as difficult, almost half of the participants believed others viewed caesarean birth as the easy option, with this perception more commonly held by participants who experienced planned caesareans. It was here the phrase “too posh to push” emerged the most often, with almost a quarter of the 32 participants spontaneously using this phrase in their birth narrative, with others typically referring to the construct without using the exact phrase.

There is the sense of society there’s a sense of having a caesarean is a cop-out. Umm that it’s what is it, too posh to push, you know, that sort of mentality going around Participant 112 (planned caesarean)

Everyone says to me, oh the caesareans easier you know, you hear this all the time. The caesareans easier, you’re in and out, you’re fine and blah be blah blah, and come on, people are electing to have it and all kind of stars have it and da de dah de dah. Participant 132 (planned caesarean)

**Others think caesarean easy and Others think caesarean hard** - Five of the participants indicated contradictory reactions from others, with reactions that indicated caesareans are viewed as both more difficult, as well as easier, than vaginal delivery. This contradiction may reflect the incongruity of attitudes that are held towards caesareans, with the opposing perceptions of the hardship of caesarean and the myth of "too posh to push" co-existing in social attitudes.

Then there was the old, umm, you know, people kind of view caesareans as a softer option, certainly know, there’s that saying at the moment, too posh to push

... Maybe I’ve got a lot more sympathy because I’ve had caesareans as well, because you know a major operation to recover from and people recognise that, more than I did actually, I had no idea that a caesarean was really a major operation Participant 114 (unplanned caesarean)
You did it wrong/You missed out – Almost a quarter of the 32 participants referred to their impression that others thought they had somehow done the wrong thing or had 'missed out' by having a caesarean. This was referred to by participants who experienced both planned and unplanned caesareans.

And every text message and thing like that since the birth has said, you know, I’m so sorry you had a caesarean and I’m so sorry your experience wasn’t what you hoped it would be, umm, oh what a shame you’ve had a caesarean, you know, never mind, the births over now, you can get on being a mother …in their minds the ideal experience or the perfect experience or most positive experience is to have a natural vaginal delivery, umm, and anything else is a failure or a different expectation to what they perceive I probably wanted.
Participant 104 (unplanned caesarean)

These participants referred to the impression that caesarean birth did not match the perceived ideal or correct birth method, with vaginal birth as a type of rite of passage to motherhood. These participants held the impression that their caesarean birth was somehow seen as incomplete by others.

It’s like, well, if you had a caesarean you haven’t had a valid birth. You haven’t had a real birth, you’re not a natural, you’re not a real mother because you haven’t, you haven’t pushed the baby out yourself. Participant 105 (unplanned caesarean)

No-one cares – Half of the 32 participants believed that others did not have a particularly positive or negative reaction to their caesarean, even when they may have mentioned perceptions that others saw the caesarean as easy, hard or as missing out. It is possible that although participants may have experienced mixed reactions, overall they may not have felt particularly judged by others regarding their caesarean experience.

Umm, fine. I haven’t noticed anyone going “oohh you had a caesarean, you didn’t have a natural birth”, no-one’s really been like that to me. Participant 101 (unplanned caesarean)
Several of the participants who described the absence of judgement from others also described a general lack of interest in their birth experience. This may have occurred because others may have been less interested in the caesarean birth experience; the participants may have been particularly sensitive to variations in interest by others; or others may have been more interested in the baby than the birth, regardless of birth method.

What have reactions been? Umm, I suppose a lot of people haven’t really been, much more interested in M after the birth and the fact that he’s here, so in fact very little focus on me. I suppose in a way I look for disappointment in a few people.
Participant 113 (planned caesarean)

One participant particularly noticed this lack of interest in her caesarean birth, and believed vaginal birth stories were somehow more interesting and therefore more acceptable to others. This participant appeared to find the lack of attention to her caesarean experience as some kind of invalidation of her birth story.

It’s funny that no-one’s really asked too much about the caesarean ... lots of people just think it’s the easy option so no-one is overly interested in what it was like … when you don’t know about something you don’t put too much thought into it about it, everyone just thinks about it being the easy option. Participant 131 (planned caesarean)

Transition and defence

More than a quarter of the 32 participants specifically referred to their impression that they needed to justify their caesarean experience. These participants felt they needed to defend why they had their caesarean, and although this impression was expressed by both participants who experienced planned and unplanned caesareans, this view was more commonly expressed by participants who had a planned caesarean birth.

But you do have a feeling that you do need to justify it umm and that people are sort of looking at you going oh how could you choose to have a caesarean.
Participant 108 (planned caesarean)
In addition to these participants who identified a general need to justify their experience, almost all of the participants responded directly to any sense of judgement they specifically perceived. Consequently, the participants who described a reaction to their caesarean that they perceived entailed negative implications, responded to it directly and contradicted any negative implication. For example, those who felt judged that they had taken the easy option emphasised the difficulty of the caesarean.

And reactions of other people, I don’t think people realise how full on an operation it is, and how much recovery time is needed, and I think they just treated it as another normal birth
Participant 105 (unplanned caesarean)

In contrast to this particular defence, most of the participants who had described the belief that others viewed their caesarean as difficult instead emphasised the lack of hardship in the operation, or the ease of recovery.

I can't get over how they keep telling you how major the surgery is ... they kept saying how major it was and I said that this is nothing compared to my back surgery.
Participant 103 (unplanned caesarean)

And my recovery was a piece of cake. I mean, we had him Thursday morning and I was ready to go home on Saturday. Participant 109 (unplanned caesarean)

Due to the individual responses to the numerous social reactions to caesareans, this resulted in several rationales or justifications that appeared to contradict one another. For example, although approximately one third of participants did not emphasise any aspect of their recovery, approximately one third emphasised the ease of recovery and the remaining third emphasised the difficulty of recovery. However, although these themes and concepts appeared contradictory, they appeared to effectively coexist as part of the participant's experiences.
When discussing a perceived sense of criticism regarding their caesarean, almost a quarter of the 32 participants rejected the idea they had either somehow missed out or done the wrong thing by having a caesarean. Several did this by specifically questioning the relevance of the concept of 'missing out' for the birth experience, while others defended the caesarean birth as valid in itself, removing any sense of missing out and instead substituting an alternative experience.

A lot of people have asked me … ‘oh did you feel like you missed out on an experience’ and I’m just like, no I just don’t.. I just think that’s something that’s perpetuated by people saying it to you. If no-one said it or brought that up, you’re just not going to feel that way I don’t think. Participant 109 (unplanned caesarean)

While I’m curious about what it would feel like or what it would be like, umm, I certainly don’t feel I’ve missed out because my experience is unique to me …I just pass that on to the next woman and say, having a caesarean is still having a delivery, just a different type of delivery. Participant 104 (unplanned caesarean)

**Justifications and New Rationale**

In addition to the reactions that were identified in direct response to perceived criticisms, several additional reasons were given to validate the caesarean birth outside of the issues of ease or validity of the birth experience. These concepts related to choice, the experience of labour, and the emphasis of the health of the baby, and appeared as part of the participant's rationale or justification of their experience.

*I had no choice* - One third of the 32 participants stressed their lack of choice in the decision to have a caesarean. Although they may previously have described the decision making process as collaborative, or indicated they had agreed to a caesarean, these participants stressed that caesarean delivery was the only option and not an actual choice in the typical sense.

I felt like it was the only option. But I felt disappointed that I wasn’t able to deliver her naturally ... I still feel like it was the only way to go. Participant 105 (unplanned caesarean)
Although the lack of choice was emphasised by participants who had both planned or unplanned caesareans, those who had experienced planned caesareans were the majority of those who emphasised their lack of choice. These participants may have been reacting against their perception of a negative response to the term 'elective', and several emphasised they perceived a particular need to justify the need for their caesarean.

Why are you having a C section? You had to explain all the time to justify why you were having a C section. Because it being elective, you know, you’re just having it you know, for the ease of not having to give birth completely naturally. But it wasn’t that way at all. Participant 102 (planned caesarean)

I laboured too - Of the sixteen participants who experienced labour prior to their caesarean, almost half of them referred to their experience of labour when discussing reactions to their caesarean. These participants implied a sense that their experience of labour somehow added to their caesarean experience, and also appeared to emphasise the difference between their experience and an elective caesareans.

I don’t feel like I’ve failed because I’ve actually pushed for two and a half hours, and I can actually say that to people. And when they say, oh well, never mind, I can say that I pushed for two hours and it wasn’t an elective caesarean. Participant 104 (unplanned caesarean)

Several of the 16 participants who experienced planned 'elective' caesareans also differentiated their caesarean from what they considered "purely elective" – caesareans scheduled for convenience without medical indication. Although none of the participants in this research met that criteria, several referred negatively to caesareans of convenience. It is possible this was done as a further defence, further legitimising their own reasons for caesarean delivery.

This whole too posh to push thing ...I kind of think, if you are going to elect to have a caesarean, for no medical reason, you should contribute financially. Participant 119 (planned caesarean)
**Healthy baby** – A third of the 32 participants emphasised the importance of a healthy baby rather than the birth process, suggesting caesarean was simply a means to an end without any inherent value. This concept was found though pregnancy for participants who expected a caesarean birth, but was not particularly prominent during pregnancy for participants who were expecting a vaginal birth, instead more likely to appear for these participants as a rationale after their caesarean birth.

I was a bit disappointed but having her happy and healthy was the priority, I would rather have had her out like that than had eight hours of pushing and having a concern the whole time that she you know, getting more and more in trouble.
Participant 131 (planned caesarean)

[Would another caesarean bother you?] No, not really. Cos I know that, it’s not the actual birth, it’s the outcome that matters. Participant 118 (unplanned caesarean)

*Cognitive dissonance*

None of the 32 participants referred to their caesarean as the wrong decision, with almost all of the participants specifically referred to the caesarean as the correct choice. However, a quarter of the 32 participants expressed some degree of disappointment or regret in their caesarean birth. These participants had experienced both planned and unplanned caesareans, although the majority of participants who expressed this view had caesareans which were unplanned. However, regardless of delivery type, disappointment appeared to be more common for those who had either held particularly strong preferences for vaginal birth, or had less warning regarding their scheduled caesarean delivery.

This sense of disappointment or missing out appeared independent of their perception of other people’s reactions, because as previously indicated, more than half of these participants suggesting that others did not appear to react to their caesarean experience (*No-one cares*).
Therefore, for some of the participant's, disappointment appeared to stem from internal rather than external influences.

I feel like I’ve missed out on something ... it’s funny that no-one’s really asked too much about the caesarean. Participant 131 (planned caesarean)

The two participants who were the most disappointed at having a caesarean birth were among those who clearly held a preference for vaginal birth throughout their pregnancy, and held this as their only expectation until problems occurred during labour. Although both mentioned the importance of having the baby delivered safely, both also struggled since the birth to reconcile their feelings of loss.

You know, because there was that big missing gap… that whole momentous thing that birth is meant to be, we just both really missed out on that. And I’ve only just started to think, oh well, it doesn’t matter now, in the scheme of things, but it really affected both of us. Participant 101 (unplanned caesarean)

These two participants appeared to view caesareans as somehow inferior to vaginal birth, perhaps relating to the 'rite of passage' concept discussed earlier, as both referred to missing the experience of giving birth.

I mean I’m sure you feel like you’ve missed out when you have a caesarean anyway, well you know, you haven’t given birth. Participant 101 (unplanned caesarean)

Because people had said to me, oh how was the birth of your baby, and I would say oh well I didn’t give birth, the doctor did. I didn’t, I can’t say I really did. And that’s just another huge part, I’ve been cheated out of the whole birthing process, I don’t feel like I’m a proper woman, for it. Yeah, I haven’t done my job properly. Participant 122 (unplanned caesarean)

Who cares – Almost half of the participants expressed that their caesarean birth experience was no longer particularly significant for them. The majority of the participants who expressed this view had experienced planned caesareans, and this may reflect the longer period of time to
assimilate the concept of caesarean birth into their expectations and preferences, or perhaps was a way to minimise the importance of the birth method and render it inconsequential. Alternatively, it is possible that for some of the participants, the method of birth may not ever have been particularly important to them.

Summary

In summary, it can be seen that participants described perceptions of being judged by others (Others - Preferences and expectations), and typically reacted by refuting each of these individually and directly (Transition and Defence). While this appeared contradictory when looking across all of the data, it presented a coherent defence for each individual participant. There were a number of additional rationales that were discussed which tended to further reinforce the legitimacy of caesarean birth (Justifications). While some of the participants were somewhat dismissive of the importance of a caesarean at all, several participants appeared to find their caesarean birth remained significant for them, and this may reflect the difficulty of reconciling their expectations and preferences with their actual birth experience (Cognitive Dissonance).

Breastfeeding

Over the course of the interviews, more than three quarters of participants referred to breastfeeding in the context of their first contact with their baby. For the participants who did not spontaneously mention this, they were asked if breastfeeding had been their intention and, if so, how they found the experience. Of the 32 participants, only one did not plan to breastfeed the baby following the birth. This participant had found the vaginal birth of her first child particularly traumatic, and as a result had particularly specific plans regarding her impending planned caesarean and bottle-feeding.
I breast fed my first child, yeah, and I didn’t really enjoy it very much ... I just didn’t really enjoy it, and I think I know myself well enough to know, and this was for the birth as well ... what do I need in my life to be able to cope well. Participant 106 (planned caesarean)

Less than a quarter of the participants did not express strong views regarding breastfeeding, perhaps indicating this was not considered a particularly consequential issue for them. The remainder of the participants, the majority, discussed their actual experience of breastfeeding (Breastfeeding great; Not that important) and how this contrasted with their earlier intentions (Preferences and Expectations). Participants gave a number of rationales to help explain their experience (Rationalisations), which included some expressing experiencing pressure from the prevailing view of “breast is best”. A quarter of participants expressed anger or distress regarding breastfeeding during the interviews, suggesting this was an important part of their total experience. There were no clear differences between participants who experienced emergency or scheduled caesarean deliveries. The themes that were identified are discussed in more detail below, and outlined in Figure 7.

Figure 7: Themes regarding experiences of Breastfeeding
Themes

Preferences and Expectations - As discussed, almost all of the participants stated that they planned to breastfeed following the birth. Over the course of the interviews it appeared the participants had given little thought to breastfeeding during their pregnancy, other than simply anticipating that breastfeeding would naturally occur.

It’s quite funny because a week before he was born we were in the supermarket and I said “hey, lets go check out the formula and see how much it is, and look how much we’ll be saving [laughter]. Participant 101

One participant was the exception and attended a breastfeeding seminar while pregnant, specifically in order to pre-empt any possible problems. Several participants briefly referred to discussing breastfeeding during antenatal classes, but three quarters of the participants appeared to anticipate breastfeeding to be fairly straightforward, with this conflicting with their later actual experience.

And again at ante-natal classes we got to hold a doll, this is how you do it thank you very much, and it’s like, oh it’s easy. Participant 103 (unplanned caesarean).

We laugh about it in our coffee group, and remember about the session in the Ante-natal class with the breast-feeding where they give you this little doll, little doll that doesn’t move, ....and then you get this wriggly ... a wriggly baby and crying baby ... then you try and get them on, it’s a bit of a joke really. I guess if they did tell what it was really like we probably wouldn’t even attempt it, if at all. Participant 120 (unplanned caesarean)

It really frustrates me even now, that the books and the midwives all say that if you get her latched on, like breastfeeding’s fine, and I don’t think that’s realistic. ... they should just be honest about that. Participant 114 (unplanned caesarean)

In light of this apparent expectation of a straightforward process, participants did not typically describe holding any particular expectations and preferences during pregnancy, with
exception of the general assumption that breastfeeding would successfully occur. Their perception of social expectations and preferences were identified more clearly when the participants were discussing their actual experience of breastfeeding.

   It’s another one of those, you know, expectations. You are expected to breastfeed your children. You do feel the pressure to do that. Participant 112 (planned caesarean)

   *Breastfeeding fine* – Almost half of the participants found breastfeeding to be relatively straightforward. These participants experienced both planned and unplanned caesareans, and when these participant's described their experiences, their descriptions tended to be very brief, more a simple acknowledgement that breastfeeding was successful.

   Yeah it was good, he’s a natural born feeder. Participant 113 (planned caesarean).

   If there were any initial problems, these did not appear to be particularly distressing for these participants and appeared to reflect: flexibility in either expectations or preferences prior to the birth; a process of rationalisation that took place following the birth; or simply that the issue of breastfeeding versus bottle-feeding was not considered particularly important or consequential to almost half of the participants.

   [When asked how she felt about her baby being given formula when she had planned to breastfeed] ... no, at the end of the day I was knocked out, the baby needed to feed, so that was fine. Participant 109 (unplanned caesarean)

   And the first night ... she was only having colostrum anyway, I think they might have given her 20 mls of formula just to settle her that night, which I said was fine. Participant 115 (planned caesarean)

   There was a clear contrast between these relatively dispassionate accounts from these participants who breastfed successfully or considered it relatively inconsequential, compared with
participants who did not have a successful breastfeeding experience and considered this a very important part of their early mothering experiences.

*Things start to go wrong* – The remaining half of the 32 participants discussed the concept of breastfeeding as hard or difficult, with the implication that it was more difficult than they had initially imagined. Several referred to the physical pain of breastfeeding, while others discussed the whole breastfeeding process as difficult to master.

Ahh the first two weeks were hell, because it was really painful, latching on and everything. Participant 124 (unplanned caesarean)

And then when it’s on your own it’s not as easy as what I thought. Participant 103 (unplanned caesarean)

I reckon the labour, the caesarean, the pregnancy, everything was about a million times easier than breastfeeding, and everyone I’ve talked to said that the labour was easier than breastfeeding ... I didn’t realise the most difficult part was the breastfeeding. Participant 114 (unplanned caesarean)

Almost half of participants described recognising that breastfeeding is the policy that is promoted in the hospitals, with a quarter of participants referring to feeling some pressure to breastfeed while in hospital, referring to both attitudes of individual staff as well as hospital policy.

I felt unsupported by the nurses, not all of the nurses but some of the nurses for bottle-feeding … and it got to the stage where I would try to feed, and he would scream, and I got too scared to ask the nurse for a bottle cos I would feel bad. Participant 101 (unplanned caesarean)

[When told if the midwives would have to give the infant formula] ... and that was like a threat. It was a threat to me ... instead of them saying look, don’t worry about it,... we can give her formula, it’s not going to kill her, it doesn’t mean that you are not going to be able to breastfeed, it’s only one feed ... Participant 114 (unplanned caesarean)

When this sense of pressure was perceived by the participants, several described feeling confident enough to disagree with what they were told by staff. However, each of these participants
had children prior to this birth experience, and appeared to have gained confidence from their previous mothering experiences.

And everyone wanted him breastfed, breastfed, breastfed, and it wasn’t optimum ... finally they relinquished and said OK do what you want. Participant 102 (planned caesarean)

Not all participants described pressure to breastfeed while in hospital, as more than a quarter of participants specifically mentioned feeling supported by midwives. They described the midwives as helpful in practical terms when learning how to breastfeed, as well as both positive and supportive.

They weren’t putting heaps of pressure on you, saying you know, you must do this ... if it doesn’t work you’re not going to die for having formula. Participant 108 (planned caesarean)

Other participants spoke of pressure to breastfeed that occurred outside of the specific hospital environment. These participants referred to their interactions with midwives, health workers and doctors who continued their care after leaving hospital, and described a culture which appeared to promote breastfeeding to the exclusion of bottle feeding.

It absolutely broke my heart to give him formula because it had been so drummed in to me, you know, by Parent Centre and the lactation consultant at Birthcare that you should never give your baby formula because of, you know, it interferes with the lining of their stomach and they can’t call you exclusively breastfeeding. Can [write on birth records] “fully breastfeeding” but not “exclusively”. It absolutely broke my heart. Participant 104 (unplanned caesarean)

I call them the breastfeeding Gestapo, you know, they just don’t give you any other option. You just feel, I felt so pressured. Participant 114 (unplanned caesarean).

In contrast to experiencing a single stance from medical staff regarding breastfeeding, several participants described experiencing a more flexible approach. This flexibility may have arisen from
midwives, the participants themselves, or a collaborative approach. This flexibility was only described positively and appeared to impact their breastfeeding experience.

This time they were more “formula and breastfeeding is fine” ... this time [with her second baby] it was disappointing but I didn’t quite feel like the failure I had the previous time. Participant 107 (planned caesarean)

The other thing is I suppose I’ve just taken the whole approach of just go with the flow and whatever is best for the baby ... the midwife came in and said shall we give her formula and I said yes please ... [and after the first few weeks] I didn’t have any problems with breastfeeding. Participant 110 (planned caesarean).

Furthermore, two participants who did not experience this flexibility specifically referred to the concept when describing their experiences. Both indicated that flexibility would have alleviated some distress and would have improved the breastfeeding or bottle-feeding experience.

Saying ... maybe it’s just not going to work and it’s okay if it doesn’t work, and here’s your options for you if it doesn’t work and you sleep on it and think about those other options. Participant 114 (unplanned caesarean)

So I think that they [breast-feeding women] definitely need the support, but not necessarily at the expense of those people who have to bottle-feed. I don’t see why the two can’t co-exist. Participant 121 (planned caesarean)

Of the half of the 32 participants who described some difficulty with breastfeeding, they described varying degrees of distress when their breastfeeding experience was initially unsuccessful or more difficult than they had anticipated. These experiences of distress ranged from fleeting to more enduring experiences, and varied in intensity.

Before that, when she wasn’t feeding, I felt really useless and anxious, stressed out and unhappy that I couldn’t give her what she clearly needed. Participant 105 (unplanned caesarean)

An absolute nightmare, I hated it, still hate it ...”. Participant 114 (unplanned caesarean)
It is possible that the flexibility of expectations mediates possible dissonance between the actual experience and prior attitudes. When expectations or preferences are perhaps less specific, this may allow flexibility that then reduces psychological distress from unmet expectations if there is a less than ideal outcome.

*Rationalisation* – Of the half of the 32 participants who experienced incongruence with their pre-existing expectations and preferences regarding breastfeeding, three quarters appeared to have developed rationalisations that helped reduce this dissonance.

[Giving formula] It absolutely broke my heart ... however, I am quite practical and so I realised that is was the practical solution to my situation ... it made me feel that I was taking care of my baby and that I was making the decision, and informed decision, and it was completely under my control. Participant 104 (unplanned caesarean)

While the participants may have described their experience as distressing at the time, many later referred to the concept that the emphasis of breastfeeding to the exclusion of bottle-feeding is unacceptable. This view of the sense of pressure as inappropriate appeared to help rationalise their own experience, as it highlighted the inequality in attitudes towards the two alternative feeding methods.

There’s no information available in the hospitals because they’re not allowed to promote bottle-feeding … it’s almost like the dark ages in a way, that whole, there was one, you know, they have the trays of pamphlets about breastfeeding, breastfeeding, breastfeeding, everyone can breastfeed, ... there’s literally no information. Participant 101 (unplanned caesarean)

I can see why mothers would get depressed. Because that would be the start of it. Definitely, you’ve got all that pressure coming in on you. Participant 102 (planned caesarean)

A quarter of the participants still appeared to feel some degree of psychological distress regarding breastfeeding. It is possible this was impacted by the participant's expectations and
preferences prior to the birth, which were typically specific with limited flexibility, or by their perception of others expectations and preferences, reflected in the sense of social pressure. Although strategies of rationalisation were used, these may have been somewhat unsuccessful as cognitive dissonance appears to remains regarding the pre-existing attitudes and subsequent actual experience.

That’s why he is still on the boob, that’s why I am still persevering. Because umm yeah, I do feel a lot of pressure, and that even more so with a caesarean rather than a vaginal birth, that one’s still really bad, you know, breastfeeding and bottle-feeding. You hear a lot about why they breast-feed but you don’t hear a lot about why sometimes bottle-feeding is better for the health of the mother and the baby. We could do with a lot more of that really. Participant 112 (planned caesarean)

In summary, although breastfeeding was not a focus during the pregnancy, after the birth it became an important focus for many of the participants. Their experiences appeared to be impacted by their expectations and preferences (including the sense of pressure) and the importance they placed on the process. If there was dissonance among these elements, in a similar process to reacting to a caesarean birth, strategies of rationalisation were used to reduce psychological distress. These strategies appeared to be somewhat less successful, as a number of the participants still appeared to be experiencing distress regarding their breastfeeding experience.

Overall Summary

The results were displayed in the order they were typically described by the participants, following the chronological order of events through their pregnancy, labour (if occurred), the birth experience, and following the birth including their infant feeding experiences. The participants described varied experiences of each stage, and yet themes were still identified that appeared to encapsulate the experiences of the participants. Some of these themes incorporated the perspectives of the participants who experienced either planned or unplanned birth, while others were more specific to each group. In particular, themes that appeared pertinent to participants regardless of type
of caesarean included those regarding the experience of pregnancy, perceptions of societal attitudes to caesareans, some of the rationalisations that support caesarean birth, and experiences of breastfeeding. Themes regarding expectations and preferences prior to the birth differed between the participants with planned or unplanned caesareans, as did some of the justifications following the birth. In addition, only the participants who underwent unplanned caesareans experienced labour so the themes related to this part of the process were specific to these participants.
CHAPTER 5.
DISCUSSION

The aim of this research was to investigate women’s experiences of caesarean birth, and explore the aspects that influenced their perceptions of their experiences. Interviews were conducted in a semi-structured way, allowing participants to discuss the factors that were the most salient to their experience. The sample included equal numbers of those experiencing planned and unplanned caesareans, allowing a contrast to be made between their experiences.

This research supported a number of previous findings regarding caesarean birth in relation to: increased rates of induction associated with caesarean birth; differences in initial interaction between mother and infant for planned or unplanned caesareans; trust in medical experts; low occurrence of 'maternal request' for caesarean; and perceptions of negative societal attitudes towards caesarean. Findings regarding the impact of epidural anaesthetic and choice of LMC on subsequent caesarean delivery were somewhat ambiguous. In addition to these findings, a central outcome of this research was the finding of shifting attitudes regarding caesarean delivery from the period prior to caesarean to the period following the caesarean delivery. That is, the majority of participants began their pregnancy with an expectation and preference for vaginal birth, yet expressed different attitudes after their caesarean. Those participants who planned to have a caesarean appeared to change their attitudes towards caesarean over the course of pregnancy, while those who expected a vaginal birth at the time of labour appeared to change their attitudes after their experience of caesarean birth. All of these findings are discussed in relation to the literature, in turn, below.

As the literature suggests, the rates of induction increase as maternal age rises, and induction has been associated with increased rates of caesarean delivery (Cunningham et al., 2005; GSSDH, 2005; HDWA, 2004). In this research, induction occurred either at the start of labour or during
labour for all but one of the participants who experienced unplanned caesareans, supporting the 
correlation between induction and caesarean delivery.

It was more difficult to establish the interaction between use of epidural anaesthesia during 
labour, and subsequent caesarean birth. Epidural anaesthetic was administered to twelve of the 
participants who experienced unplanned caesareans for a number of reasons including; pain relief 
during labour; pain relief once caesarean delivery was being considered; and solely for the purpose 
of anaesthetic for the caesarean surgery. A relationship between use of epidural anaesthetic and the 
length, or quality of labour, could not be established, and ambiguity regarding anaesthetic was not 
clarified by participants during the course of the interviews.

However, this study supported previous findings regarding the negative sequelae of general 
aanaesthetic (Clement, 2001; Fisher et al., 1990; Garel et al., 1987; Herishanu-Gilutz et al., 2009; 
Reichert et al., 1993). Each of the participants who experienced general anaesthetic made either 
ambiguous or negative comments regarding their experience, all expressing a preference to be 
'present' for any future births. This supports the tenant that giving birth is a significant experience, 
and when women are unconscious for the birth they may have a sense of loss from missing this 
important event (Clement, 2001; Cohen, 1977; Fenwick, Gamble, & Mawson, 2003; Fenwick, 
Holloway, & Alexander, 2009). In addition, researchers have suggested the violation of 
extpectations can significantly impact reactions to the birth experience (Boyce & Condon, 2001; 
Fenwick et al., 2006; Goodman et al., 2004; Ryding et al., 2000). General anaesthetic may represent 
a specific challenge to expectations, as most women anticipate that if any anaesthetic were to be 
used, it would be epidural in nature, which may add to the negative impact of general anaesthetic.

Participants who experienced unplanned caesareans had slightly longer average delays before 
first contact with their baby following birth, and were a little more negative in their perception of the 
delay and initial contact experience. This supports previous research findings which have suggested
caesarean delivery, particularly unplanned, may have a deleterious impact on initial mother-infant interaction (Garel et al., 1987). However, later descriptions of their infants were indistinguishable between participants who experienced either planned or unplanned caesarean. All descriptions contained similar positive adjectives, supporting literature that suggests the type of birth may have no long-term impact on mother-infant interactions (Durik et al., 2000). Once again, it may be the conflict between the expectations of the first contact (immediate contact, holding the infant after birth in a labour room), versus the actual experience (delayed remote contact, in an operating theatre or recovery room), that negatively impacts the interpretation of the experience.

Alternatively, it is possible women may perceive stigma for not achieving initial 'skin on skin' contact following birth. Stigma has been linked to birth-related processes that are considered to be less than ideal, such as caesarean birth and bottle-feeding (Lobel & DeLuca, 2007; Marut & Mercer, 1981; Schmied & Barclay, 1999; Schmied et al., 2001). Although this has not been specifically researched, it is possible stigma may also be perceived when initial interaction following birth is not achieved. Distress from unmet expectations or perceptions of stigma regarding post-birth interactions may reduce over time as the experience is rationalised as part of the birth process, perhaps demonstrated in this study by the participants affirming their ongoing bond with their baby. In addition, as noted earlier, prior research suggests a negative birth experience does not necessarily have a negative impact on the later view or relationship with the baby (Shearer, 1983).

The relationship between choice of LMC and subsequent caesarean surgery was also not straightforward in this research. All but one of the participants who experienced planned caesareans had specialists as their LMC, which supports research findings that suggest specialists are more likely to be involved in caesarean births (Johnston, 2005). However, this also reflects accepted practice within NZ, with specialists typically utilised in pregnancies that are complicated, high risk, or require caesarean delivery (Kutinova, 2008). Of the 16 participants who experienced unplanned
caesareans, 11 were under the care of a midwife, while five were under the care of a specialist throughout their pregnancy and stated this as their preference. Therefore, although participants who experienced planned caesareans were more likely to have a specialist as their LMC, the role of specialist as LMC did not necessarily imply an increased likelihood of caesarean. Regardless of type of LMC, the confidence held by the participants of this research in their medical professionals supports previous research findings that emphasise the role of the medical profession in the caesarean birth experience (McCourt et al., 2007). In addition to providing confidence in the decision-making process, this confidence in "the experts" also seemed to reduce anxiety for the participants during the caesarean surgery, reflecting the considerable influence held by medical professionals in the birth process (Crossley, 2007; Sandin-Bojo et al., 2008).

When assessing reasons for caesarean delivery in this research, all breech deliveries were delivered by planned caesarean in keeping with NZMOH policy (NZMOH, 2004), with the exception of one instance when the breech presentation was not identified prior to the birth. Two of the six participants who had experienced previous caesarean delivery attempted a VBAC, higher than the rate of 10% for VBAC in the US (Martin et al., 2005); although comparable with other published NZ rates for VBAC (NWH, 2000; Pot et al., 2008). The remainder of the participant's who possibly could have attempted VBAC and instead chose a planned caesarean, indicated they primarily followed medical advice when making their decision regarding method of birth (Goodall et al., 2009).

Half of the participants of this research experienced planned caesareans, although none appeared to fall in the classification of “maternal request”, as the decision for each caesarean was due to medical reasons and made with the consultation of medical specialists (Goodall et al., 2009). This supports research findings that suggest rates of maternal request for caesareans may be over-
estimated if taken out of context from the factors that impact the decision making process, including the influence of the advice of medical specialists (Berry, 2007; Bourgeault et al., 2008).

The concept that society generally views vaginal birth as superior to caesarean birth was reported by the majority of participants in this study. This aligns with research findings that suggest the popular media contributes to the devaluation of caesarean birth, with the use of the phrase "too posh to push" in association with caesareans, particularly elective caesareans (Berry, 2007). The reaction of participants to the phrase 'elective' further indicates that the implication of maternal choice entailed by the word 'elective' somehow exacerbates invalidation of their caesarean experience (Bourgeault et al., 2008). Several of the participants suggested the term "medically indicated" as a preferable and more accurate descriptor of their planned caesarean, reflecting that the decision for caesarean was in response to medical advice, although it appears likely this alternative label would increase the stigmatization of planned caesarean's performed for non-medical reasons.

During the process of data analysis it became obvious that at some point during pregnancy or following the birth, the majority of participants experienced a shift in their viewpoint in favour of caesarean birth. Although this shift in attitudes was not explicitly discussed, by the time the interviews took place the majority of participants appeared to view their caesarean as the preferable birth option, contradicting their original intentions and preferences. As discussed earlier, cognitive dissonance theory suggests that when behaviour contradicts values and beliefs, the resulting psychological discomfort is difficult to tolerate (Festinger, 1957). Therefore, attempts will be made to reduce this dissonance, and this appears to have occurred for the participants of this research.

Many of the sixteen participants who experienced planned caesarean births initially held at least some expectation or preference for vaginal birth. However, at some stage of their pregnancy the decision was made that they would give birth via caesarean delivery. This meant they had the opportunity to readjust their preferences and expectations prior to the birth, align them with their
planned caesarean, and therefore reconcile attitudes and behaviour prior to the actual caesarean surgery. The participant's who planned for a caesarean in the earliest stages of, or pre pregnancy, held robust rationales for their caesarean and appeared to hold no regrets following caesarean birth. These participants were also the most vocal regarding their perception of social bias against caesareans and pressure for vaginal birth.

There are a number of possible explanations for why participants with the longest planning time prior to caesarean were especially vigorous in challenging societal views. It is possible the longer time-frame allowed adjustment to the idea of caesarean and gave the opportunity for any defending rationalisations to be well developed. In addition, this longer time period may have led to more occasions when they felt they had to defend their plan for caesarean, and therefore these participants may have become hyper-vigilant in perceiving negative judgemental social views. Alternatively, they may have experienced more negative reactions from others because they were having 'elective' caesareans. Finally, perhaps perceiving negative attitudes from others as judgemental may have reduced their perceived veracity and allowed negative judgement to be more easily dismissed.

Psychological distress appeared to occur when participants initially held strong expectations or preferences for vaginal birth, supporting previous research findings (Cranley et al., 1983; Goodman et al., 2004; Ryding et al., 2000). For example, one participant expressed a clear preference and expectation of vaginal birth, but pre-eclampsia during the later stages of her pregnancy necessitated a planned caesarean delivery. Her subsequent sense of disappointment that the birth did not match her expectations and preferences may reflect the short timeframe she had to develop a robust rationale, which may have been insufficient to align her expectations with revised plans and thereby negate cognitive dissonance.
Cognitive dissonance theory suggests the use of strategies designed to align behaviour and attitudes can be applied both for future situations as well as retrospectively (Festinger, 1957; Kay et al., 2002). Previous research related to birth expectations has suggested responses to cognitive dissonance after an initial caesarean birth led to changes in attitude regarding future caesareans (Hauck et al., 2007).

In the present study, it is suggested that in addition to changing attitudes about future pregnancies, the process of rationalisation could occur during pregnancy before the caesarean had occurred, upon learning the impending birth would be caesarean. In addition, the present study also found cognitive dissonance following caesarean birth can lead to strategies that can then be applied retrospectively to bring the unexpected experience of caesarean birth back into congruence with attitudes and preferences. Specifically, the contrast between initial perceptions and later reconciliation appears to demonstrate the use of retrospective strategies in order to reduce cognitive dissonance. This process can be seen through the progression of the themes through Expectations and Preferences; Transition; and Rationalisation. For participants who could not completely rationalise their experience, the residual cognitive dissonance was reflected in an enduring sense of distress or disappointment regarding their birth experience.

Some participants appeared to continue to experience conflicting emotions and attitudes regarding their experience. These participants did not appear wholly convinced by their evolving rationale for why their caesarean was the preferable choice, and were left with some psychological discomfort. It may be that some participants were aware that they had reframed their expectations, and therefore could more readily access their initial attitudes and acknowledge a sense of residual disappointment. This is consistent with cognitive dissonance theory which suggests cognitive alignment is most effective when it occurs without conscious awareness (Festinger, 1957; Gilbert et al., 1998).
As an alternative to this theory, it is possible that expectant mothers really only care that their baby is healthy, and although their expectations for vaginal birth may not be met, any preference regarding birth method may be discarded through the process as irrelevant as long as the end result of a healthy baby is achieved. Although few would deny the ultimate outcome of the birth process is a healthy baby, focusing only on a healthy baby does not explain the effort some participants put into birth plans for vaginal birth; their sense of perceived stigma or sense of failure if vaginal birth is not achieved; or the sense that caesarean birth needs to be justified to others. In this research study, preferences and expectations appear relevant to the birth process, as well as later integration of the experience.

Exceptions occurred for each theme in the data analysis process, with some participants not appearing to experience any cognitive dissonance or psychological discomfort in relation to the caesarean birth. Research has found that cognitive dissonance does not occur when beliefs or attitudes conflict with behaviour in circumstances that are considered somewhat inconsequential (Kay et al., 2002). This may mean that it requires more than simply unmet expectations to potentially result in cognitive dissonance, so when the birth type is not important or meaningful, unmet expectations would not create any negative emotional response. Therefore, it appears that it is the interaction of other factors, such as preferences, that are necessary in order to make the unexpected event somehow consequential to the individual. In this research, participants without strong expectations or preferences appeared somewhat indifferent to their caesarean experience, without any particular emotional response to the birth. This appears to be a different process from those who gave rationalisations that minimised the importance of birth method and emphasised the birth outcome (i.e., health of the baby), which may reflect efforts to displace cognitive dissonance.

Of the thirty two participants in this research, the two who continued to display considerable distress regarding the caesarean birth had clearly expected vaginal birth and had described holding
very strong preferences for vaginal birth throughout their pregnancies. The remaining participants who described a sense of continuing disappointment regarding their caesarean birth had varying expectations, with both planned and unplanned caesareans, but each described a strong preference for vaginal birth throughout pregnancy. Thus, the participants who held the strongest expectations and preferences for vaginal birth appear to display the most psychological distress or cognitive dissonance following caesarean because the caesarean experience holds more significance for them, as would be expected from cognitive dissonance theory (Kay et al., 2002).

It is difficult to identify the specific point of the birth process when expectations and preferences shifted for many of the participants who had unplanned caesarean deliveries. This stage was referred to as ‘transition’ to indicate conflict between expectations and their actual experience. However, this does not necessarily mean cognitive dissonance was dispelled at this point, rather that this was the period during which it became evident that actual events would not match preferences and expectations. In addition, a number of participants described feeling disconnected, or that the situation was surreal at this stage of labour; the majority of whom were participants who experienced unplanned caesareans, with one third describing this sensation. As noted, it is difficult to separate the effects of medication from the process, but it is possible this disconnection may indicate psychological discomfort participants were feeling at this first indication their expectations and preferences were not going to be met.

The theory of cognitive dissonance was also relevant to the participant's experience of breastfeeding. Although themes around breastfeeding were not particularly prominent during pregnancy, the majority of participants clearly held the expectation and preference they would breastfeed following the birth. For those participants who did not particularly value breastfeeding, there was no psychological distress if this did not occur. However, for many, the actual breastfeeding experience did not match initial attitudes, leading to cognitive dissonance and
psychological distress. For most, this appeared to be resolved through strategies of rationalisation, once again retrospectively, that helped reconcile their experience and attitudes. This finding of similar processes occurring across birth method and feeding method is relatively unsurprising given their close proximity of occurrence and association with the first stages of motherhood (Schmied & Barclay, 1999). In addition, the general perception that both vaginal delivery and breastfeeding are perceived as superior to their alternatives (i.e., bottle feeding; caesarean birth) entails similar feelings of failure, defensiveness and perceived stigma when the ideal cannot be achieved, contributing to negative outcomes and possible dissonance. In this research, one of the two participants who described the most distress following caesarean was successful in initiating breastfeeding, and referred to her sense of relief that she could complete one important mothering process, supporting previous research findings (Schmied & Barclay, 1999). The other participant who described the most distress following caesarean was unable to establish breastfeeding, and made considerable comment on her sense of negative social judgement regarding this. It seems possible her distress was perhaps escalated through some form of 'double dissonance', which may indicate potential future areas for research.

**Clinical implications of findings**

This study has added to the body of research regarding factors related to women's experience of caesarean delivery, including associations with induction, types of anaesthetic, and LMC; as well as research regarding attitudes and reactions to caesarean birth. Given the increasing rate of caesarean deliveries, now almost a quarter of all births in NZ (NZHIS, 2006), research conducted into women’s experiences must be considered of increasing relevance, particularly in light of conflicting research on the psychological sequelae of surgical delivery (Astbury et al., 1994; Carter et al., 2006; Chen & Wang, 2002; Fisher et al., 1997; Green et al., 1990; Hannah et al., 1992; Keogh
et al., 2006; Lobel & DeLuca, 2007; Marut & Mercer, 1981; Mercer et al., 1983; Mutryn, 1993; Page, 1999; Reichert et al., 1993; Ryding et al., 2000). As well as supporting previous research findings, this study helps explain why the impact of caesarean section delivery can be so variable. The complex interaction of social values and judgements with an individual’s expectations, preferences and rationalisations cannot be easily predicted prior to birth. This research supports the findings that planned caesareans have less negative psychological impact than unplanned caesareans.

It is suggested that this is a result of women having more time to align their expectations and preferences with caesarean delivery prior to the birth taking place. This may not simply be the unexpected nature of emergency caesarean that has a negative impact, but the dissonance between preferences and attitudes, combined with the lack of time to address this, that may result in psychological distress, potentially exacerbated by the attitudes and reactions of others.

Prior to birth most sources of information (e.g., media, antenatal classes, books, peer groups) advocate vaginal birth as preferable to caesarean birth (Berry, 2007; Bourgeault et al., 2008; Fitzsimons, 2001; Marsh, 2006; Schmied et al., 2001; Song, 2004). Antenatal classes and midwives talk about the ‘cascade of interventions’ which increase the likelihood of caesarean delivery. During these discussions the probability of difficult recovery from caesarean is stressed, and the promotion of earliest possible skin-on-skin bonding time following birth fits best with a vaginal birth model. While the intent of this information may be to increase the likelihood of the “best birth” for pregnant women, it may impact preferences to the extent that it negatively impacts those who experience caesarean delivery. Thus, there may not be any specific information that suggests caesareans are "bad", but instead it may be the perception that caesarean births are inferior to vaginal birth that contributes to the later sense of distress following caesarean delivery. This research demonstrated how the pervasive view of vaginal birth as superior to caesarean birth can contribute to cognitive
dissonance, and how this and stigma around caesarean delivery can necessitate the use of cognitive strategies to reduce resulting psychological distress.

The number of participants in this research who reported psychological distress related to breastfeeding indicates that this was also a significant issue. This current finding of a sense of pressure to breastfeed supports other research findings suggesting current emphasis on breastfeeding may inadvertently have iatrogenic effects (Schmied & Barclay, 1999; Schmied et al., 2001). Similar to expectations for vaginal birth, this research indicated the pathway through which messages about advantages of breastfeeding, when delivered in the absence of any material related to bottle-feeding, can contribute to the development of rigid expectations and preferences for methods of feeding. While breastfeeding rates have increased from the low rates of the mid-1980's (Fielding, 1997), it needs to be acknowledged that when women find breastfeeding difficult or untenable, they appear to be left with a sense of guilt, disappointment (Schmied & Barclay, 1999; Schmied et al., 2001), and possibly cognitive dissonance that then needs to be resolved.

This research suggests that, when actual experience does not match the 'ideal' experience, psychological distress may not relate to the actual experience but instead to the attitudes about the experience. It is possible that caesarean delivery and bottle-feeding are not inherently less satisfying than vaginal delivery or breastfeeding, but the perception they are inferior creates the sense of distress. Therefore, although there are a myriad of valid reasons supporting the advocacy for vaginal birth and breastfeeding, there needs to be something in place to validate alternative experiences. While women may achieve validation themselves via strategies designed to help alleviate cognitive dissonance, there potentially may be changes to the information given prior to the birth. This may allow for more fluidity in expectations and preferences that may reduce the psychological distress if the expectations and preferences are not met, and researchers have already indicated a need change in relation to breastfeeding information (Schmied et al., 2001). Therefore, there appears to be a need
for greater education of the public as well as antenatal educators to ensure the promotion of vaginal delivery, topical in a climate of escalating caesarean rates, does not entail concurrent devaluation of caesarean delivery. Caesarean birth needs to be discussed and understood, for people to know how commonly they occur, for the acknowledgement of the impact of general anaesthetic on the birth experience, and medical reasons for caesarean birth to be understood rather than caesarean simply seen as 'too posh to push'. In addition, the use of the terms 'elective' and 'emergency' should perhaps be evaluated and renamed with terms that accurately reflect the caesarean experience, without carrying extraneous connotations perceived by the current terms.

It is also worthy of note that even when women have a birth experience that does not match their expectations and preferences, their use of cognitive strategies can help to mitigate the situation. While this research does not prescribe specific therapeutic techniques to use with women who experience psychological distress following caesarean birth, it suggests a framework that can help conceptualise the distress and offer pathways to help reduce this. Therefore, further research may indicate ways in which women who are experiencing psychological distress may be helped to develop strategies to reduce cognitive dissonance.

**Strengths and Limitations of the research**

The research design gave the opportunity to investigate women's caesarean experiences from their own perspectives and allowed them to highlight the aspects of the process that were most relevant to them. The qualitative nature of this research, while limiting its generalisability, gave scope for the exploratory nature of the research. The emerging themes arose from the data rather than purposefully mapping the interviews to a pre-existing theory. The researcher bought her own baby to all of the interviews, which typically occurred in the participant's own homes, and rapport
was quickly established, perhaps because the participants assumed at least some kind of shared understanding of the birth experience.

As this research was exploratory, no theory was specifically investigated during the course of the interviews. This meant that ambiguities in the narratives regarding specific topics or previous research findings were not clarified at the time of interview, such as those relating to reasons for choice of LMC or anaesthetic, and therefore these could not definitively be evaluated through data analysis. In addition, the theory of cognitive dissonance was not specifically investigated. Instead, it was identified as an explanatory hypothesis during the process of data analysis to help make sense of the shifting attitudes of the participants. While this means that cognitive dissonance was not originally a focus of the research and therefore was not specifically investigated, its relevance to caesarean birth aligns well with other research, perhaps implying additional validity to these findings, but possibly leaving aspects of cognitive dissonance unexamined.

The retrospective nature of the interviews means it is not possible to clarify a number of issues, including whether the preference or ambivalence regarding birth method altered following the birth. These may have differed if the women could have been asked about their preferences during pregnancy, or before any of them knew they were having a caesarean birth. However, the majority of participants who experienced unplanned caesareans denied thinking about the prospect of caesarean during their pregnancy, so this may not have elicited much comment from those participants.

Further, limitations include the relatively small number of participants, and their relative homogeneity in terms of demographics (i.e., age and education). The average age of participants was slightly higher than the national average age for giving birth (NZHIS, 2006), although caesarean rates rise with increasing age so this could possibly be expected. The participant’s were selected across the central Auckland city area by an impartial organisation so although relatively
homogeneous, the selection was random and external to the researcher. Furthermore, this selection process led to thirty two participants who were sorted into evenly numbered groups by their degree of planning for their caesarean, which allowed for contrast between the two groups.

Finally, the researcher's perspectives and subjectivities must be acknowledged as part of the process of qualitative research (Morrow, 2005). While trying to be aware of my own process; during the interviews, data analysis and theme construction, I was cognizant of using my own caesarean experience to allow insight into aspects of the caesarean process, without generalising it beyond that and presuming my perspectives were shared by the participants. As discussed previously, I did not disclose my own birth experiences to the participants until after the completion of the interviews if asked, with one exception when specifically asked by a participant during the course of an interview. In addition, immersing myself in the data allowed the participants stories to gain their own prominence, with their birth narratives creating their own themes external to my own experience.

Implications for Future research

The emergence of cognitive dissonance theory as a possible explanatory hypothesis for levels of distress following caesarean was identified through the data analysis process, and the congruence between this and other research findings seem to support the authenticity of the findings. Future research, particularly if conducted prospectively, could elaborate on the shift in expectations and preferences both before and after birth. This would help identify the extent of any shift, and establish any period during which change in attitudes typically occurs, and whether particular 'critical periods' for this shift can be targeted to reduce negative impact.

Future research could specifically investigate aspects of flexibility, as well as try to establish the importance that participants place on the birth process before it occurs, which would help differentiate between participants who perceived the birth process as relatively inconsequential and
those who diminished its importance as a strategy to reduce cognitive dissonance. Furthermore if conducted with more participants, it could perhaps give more detail on the processes used to achieve cognitive congruence and better identify the specific strategies that could be useful for those still struggling with psychological distress.

Future research could potentially identify the point at which material which promotes vaginal birth and breastfeeding can achieve its objective before it becomes deleterious to women who do not achieve these outcomes. This could then assist in the development of strategies that positively impact vaginal birth and breastfeeding rates without contributing the perception of stigma.

Conclusion

This research supports a number of previous research findings regarding associations between caesarean and induction, initial differences in first interaction with the infant following birth, trust in medical experts, low numbers of maternal request caesarean, and consistency regarding perceptions of societal attitudes towards caesarean birth. This study offered somewhat ambiguous findings regarding any association between caesarean birth and choice of LMC, or anaesthetic. In addition, this study suggests that women’s experiences of caesarean birth (and subsequent breastfeeding experiences) are impacted by expectations and preferences held during pregnancy and following the birth, as well as societal attitudes and expectations. Conflicts between pre-existing attitudes and the actual birth experience may generate cognitive dissonance which can lead to psychological distress. Strategies can be utilised which reduce this dissonance in order to validate the caesarean birth experience. As well as impacting upcoming births, these strategies can be applied retrospectively to reduce cognitive dissonance and psychological distress.
APPENDIX A - Semi-structured Interview

The participants will be asked to describe their experience of giving birth by caesarean section delivery. If they do not cover the specific areas of interest, the participants will be asked to describe these after they have completed their narratives. These areas are:

**Pregnancy**
- How did the mother find the pregnancy
- What were the expectations for the birth

**Birth**
- The decision-making process for the surgery
- The language/terms used by medical staff when discussing the reason for caesarean birth

**Reactions to birth**
- The mothers response to a caesarean birth, both immediately and later after the birth
- Social responses (friends, family, acquaintances) to their birth experience
- Was breastfeeding the preferred method of feeding the baby? If yes, was this possible after the caesarean birth?
- Had they had other children before this birth? If yes, how were they delivered? If different, how did the mother find the differences?
- How would the mother describe her child/children?
APPENDIX B – DMQ: Investigating the experience of Caesarean Birth

This questionnaire contains a number of questions regarding your demographic details, background, and circumstances of your birth. If you have any questions when completing this, please feel free to contact the primary researcher: Leanne Taylor-Miller ph 373 7599 extn 88515.

BACKGROUND QUESTIONS

Name: __________________________________________________________

Address: __________________________________________________________

____________________________________________________________________

Age __________

Ethnicity __________

Relationship status (Please circle)

Single    Married    Separated    Divorced    Partnered    Other

Age of children __________________

Birth experience/s

Number of caesarean births __________________

Number of non-caesarean births __________________

Was the caesarean birth/s (please circle) Planned Unplanned Unexpected

Other (please explain)

____________________________________________________________________

What was the main reason for the caesarean birth/s?

____________________________________________________________________

What was the main anaesthetic for the caesarean birth (please circle) General Epidural

How long after the caesarean birth were you able to see and touch your baby? __________

I would like to be sent a summary of the findings from this research when they have been compiled (please circle) Yes  No

Thank you for taking the time to answer these questions.

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APPENDIX C

Notice for Plunket Staff

Dear Plunket Staff Member:

I am studying women’s experiences of giving birth by caesarean delivery as part of thesis research for my Doctorate in Clinical Psychology at the University of Auckland.

I am interested in speaking to women who have given birth by caesarean delivery within the last eighteen months, and would appreciate it if you could pass information about my study to potential participants.

What is the research about?
This research project is about the birth stories of women who have experienced a Caesarean delivery. Participation will involve a one hour (approx) confidential interview in which women who have experienced a Caesarean delivery will discuss their birth experience with me. I am interested in not only hearing about birth stories from this special group of women, but also exploring with the participants how they found the process of undergoing a Caesarean delivery and how they subsequently recovered from the surgery. After I have spoken to thirty women who have recently experienced a Caesarean delivery, I will then look at all of the women’s experiences collectively and look for common themes in their birth stories. I will then depict the common themes that emerge from the birth stories in my Doctoral Thesis.

Attached is a Participant Information Sheet, Consent Form, and pre-paid envelope. If women are interested in participating, they simply need to read the Participant Information Sheet. If they are still interested in the study after reading this form, they can return the Consent Form to me in the pre-paid envelope. I will then contact the prospective participant by telephone to arrange a confidential interview at a location of their convenience. If anyone has any questions they would like to ask, they can contact me by telephone before returning any information.

Your help
If you have a client that has had a Caesarean delivery in the last eighteen months and you think she may be interested in participating in my research, could you please give her a Participant Information Sheet, a Consent Form, and a prepaid envelope on my behalf?

Thank you very much for your help. It is much appreciated!

Best wishes,

Leanne Taylor-Miller
Phone: 373 7599 extn 86088
Dear Potential Participant:

I am studying women’s experiences of giving birth by caesarean delivery as part of thesis research for a Doctorate in Clinical Psychology at the University of Auckland. I am interested in speaking to women who have given birth by caesarean delivery within the last eighteen months.

This research project is to explore the birth stories of women like yourself who have experienced a Caesarean delivery. Participation will involve a one hour (approx) confidential interview in which you will have the opportunity to discuss your birth experience with me. I am interested in not only hearing about your birth story, but also learning from you how you experienced the process of undergoing a Caesarean delivery and how you subsequently recovered from the surgery.

After I have spoken to thirty women who have recently experienced a Caesarean delivery, I will then look at all of your experiences collectively and look for common themes across the birth stories. I will then depict the common themes that emerge from the birth stories in my Doctoral Thesis. When completed, this will be deposited into the University Library and available to interested researchers.

Attached is a Participant Information Sheet, Consent Form and pre-paid envelope. If you are interested in participating, please read the Participant Information sheet. If you are still interested after reading this form, please return the Consent Form to me in the attached pre-paid envelope. I will then contact you by telephone to arrange an interview.

If you have any questions you would like to ask, you can contact me by telephone before returning any information. There is no obligation you to participate in the project, and you can withdraw from the research at any stage of the data collection process.

Wishing you all the best,

Leanne Taylor-Miller
Phone: 373 7599 extn 86088
APPENDIX E - PARTICIPANT INFORMATION SHEET

Title: Investigating the experience of Caesarean Birth

What is the project about?
This project aims to investigate the experience of mothers who give birth by Caesarean sections. We would like to talk to you about your perceptions and experiences of giving birth by a Caesarean delivery. Information from this study will then be used both to inform other women who may undergo a Caesarean delivery in the future and to improve maternal health services in New Zealand.

Who is doing the project?
The project is being done by a team of three people based at the University of Auckland’s Department of Psychology. The team includes (1) a Health Psychologist who is the project supervisor and maternal mental health specialist Dr. Jackie Summers, (2) a lecturer and clinical psychologist who specializes in trauma recovery Dr. Andrew Moskowitz, and (3) a postgraduate student studying for the Doctorate of Clinical Psychology at the University of Auckland Leanne Taylor-Miller.

What sorts of questions will you be asked?
The purpose of the interview is to learn more about how Caesarean births are experienced, so maternal health services can be improved to better support women who have surgical deliveries. To do so, Leanne Taylor-Miller will ask you about your birth experience and your perceptions of support services available for women such as yourself who have Caesarean deliveries. We are interested in finding out about your experience so we can learn about what you found to be useful before, during, and after your delivery. If you feel any discomfort while discussing your experiences, you can let Leanne Taylor-Miller know either during the interview or later by telephoning 09 373 7599 extn 88515, or you can contact the post-natal support organisations that will be provided in a list at the end of the interview.

Where will the interview take place and how long will it take?
Leanne Taylor-Miller would meet with you once at a location that is convenient to you, such as your home or an office space at the University of Auckland. The interview would take about one hour.

What happens to the information?
The interview will be audio-taped on a tape recorder so Leanne Taylor-Miller can transcribe what you say at a later date. Your participation will be kept confidential and all information provided will be used in an anonymous manner. Your demographic information will be coded with a random five digit code and locked in a filing cabinet in the project supervisor’s office at the University of Auckland. Your interview information will be coded with this same five-digit code and no other identifying information will be used during the transcription. Notes from the interview will also be coded with this same random five digit code and kept in a locked filing cabinet in the supervisor’s office at the University of Auckland. We will not reveal any identifying information about you to anyone outside of the research team, and the information given in this interview will be held for up to three years and then destroyed. At the end of the project, the results will be reported in a way that will not allow for you to be personally identified. Leanne Taylor-Miller will send you a summary of the research findings at the conclusion of the study.

Participation is completely voluntary.
You can withdraw from the project at any time before December 1, 2005. Participation is completely voluntary.

Thank you very much for your time and help in making this study possible. If you have any queries or wish to know more, please contact us at:

Leanne Taylor-Miller, Research Associate  
Department of Psychology  
The University of Auckland  
Private Bag 92019  
Auckland.  
Tel. 373 7599 extn 88515 or 021-2455-234

Project Supervisors:  
Dr. Jackie Summers  
Department of Psychology  
The University of Auckland  
Private Bag 92019  
Auckland.  
Tel. 373-7999 extn 83794

Dr. Andrew Moskowitz  
Department of Psychology  
The University of Auckland  
Private Bag 92019  
Auckland.  
Tel. 373-7999 extn 88553

The Head of Department:  
Professor Fred Seymour  
Department of Psychology  
The University of Auckland  
Private Bag 92019  
Auckland. Tel. 373-7999 extn. 88414

*********************************************************************

For any queries regarding ethical concerns please contact:

The Chair  
The University of Auckland Human Participants Ethics Committee  
The University of Auckland  
Research Office - Office of the Vice Chancellor  
Private Bag 92019  
Auckland  
Tel. 373-7999 extn 87830

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE on 10 March 2005 for 6 years from 03/05 to 03/11  Reference Number 2005/017
**CONSENT FORM**

**Title:** Investigating the experience of Caesarean Birth

**Researcher:** Leanne Taylor-Miller, Jackie Summers, Andrew Moskowitz

- I have been given and have understood an explanation of this research project. I have had an opportunity to ask questions and have had them answered to my satisfaction.

- I understand I will be audio-taped during the interview, and that this will be used for the purposes of transcription and analysis only.

- I understand that the information I give in this interview will be held for up to three years and then destroyed.

- I understand that I have the right to withdraw any information at any time prior to 1\textsuperscript{st} December 2005.

- I understand that if anything raised in the interview causes me to feel uncomfortable or distressed in any way, I may contact Leanne Taylor-Miller by telephoning 09 373 7599 extn 88515, or contact the list of post-natal support organisations that will be provided during my interview.

- I understand that my participation in the research is voluntary, and that I am free to withdraw from the research at anytime.

- I understand that my participation is confidential and that I will not be identified in any way in the final evaluation or research report.

- I agree to take part in this research.

Signed: ___________________________

Name: ___________________________

(please print clearly)

Date: 

**APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE on 10 March 2005 for 6 years from 03/05 to 03/11 Reference Number 2005/017**
Participant 105 is a 32 year old Pakeha woman who lives with her husband and 5 ½ month old daughter. She had some problems with her pregnancy with some concern over contractions that occurred from 28 weeks. 105 was concerned about premature labour as she and her siblings were all born prematurely. This did not eventuate as she went full term, but she experienced considerable swelling by the end of pregnancy.

Her plan for the birth was to go to Birthcare and have a water birth. The labour began with her waters breaking, with contractions following some hours later. She and her support people [travelled into the city] and the labour continued at [a birthing unit]. The labour went as planned with her spending time in the birth pool until she was fully dilated. However, after spending several hours pushing, it became clear things wouldn't progress. 105 could also feel that the pushing wasn't working, and later found out that the baby was monitored as being in distress.

She went via ambulance to the hospital (which she found very difficult), and after assessment it was agreed that the baby would not birth vaginally, so she needed an emergency caesarean.

As the baby had respiratory distress, 105 only saw her briefly before she was taken to NICU, briefly at NICU on her way to the ward after spending time in recovery alone, and could not hold her until the next morning. She then had considerable issues regarding feeding (with NICU staff feeding the baby through a nose tube) with the baby in NICU for 4 days. Initially felt disconnected from the baby, but now fine.

Summary.
Pregnancy - ok. Expectations - fearful before antenatal classes and after these was very positive about the birth. Decision making – 105 felt in control until she reached the hospital, then lost the control. After that she felt things were out of her control. Language – was couched in terms that there weren't really any other options, and agreed that it was inevitable. Worry/fear – had some concerns for the baby. Control – as above, felt in control during labour, and then out of control until the baby was back in her room (after 4 days in NICU). Support – had a great deal of support through the labour (husband, mother, friend, midwife), but none really during the birth, or in particular felt very alone in recovery. Did appreciate the Dr's telling her that she would not necessarily need a c-section for future deliveries. Time before contact – has issues with this as felt very disconnected from baby. Reactions – felt was inevitable, but was disappointed. Social – feels people think it is the easy way (including some midwives) and always says she had the whole labour and feels this gives her more credibility. Breastfeeding – yes, preferred. Problems, particularly with a nosetube at NICE as felt this reduce the baby's appetite and had such a delay before feeding, but now established. Baby – lovely.
## APPENDIX H  
### Participant Profile

<table>
<thead>
<tr>
<th>Participant</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>101</td>
<td>26 year old Pakeha woman who lives with her partner and their 5 month old baby boy. After going into spontaneous labour, she ended up with an unplanned caesarean birth under general anaesthetic as the labour 'failed to progress'.</td>
</tr>
<tr>
<td>102</td>
<td>34 year old Pakeha woman who lives with her husband, 7 year old son and 8 week old baby. She had a planned caesarean due to a 4th degree tear after her previous vaginal birth.</td>
</tr>
<tr>
<td>103</td>
<td>38 year old Jamaican woman who lives with her husband and 8 week old baby boy. She had an unplanned caesarean after the labour failed to progress. The caesarean was under general anaesthetic as she had experienced previous surgery for a back injury so could not have epidural anaesthetic.</td>
</tr>
<tr>
<td>104</td>
<td>37 year old Pakeha woman who lives with her husband and 9 week old baby. She was induced and had an unplanned caesarean due to 'failure to progress'.</td>
</tr>
<tr>
<td>105</td>
<td>32 year old Pakeha woman who lives with her husband and 5 ½ month old daughter. She went into spontaneous labour and had an unplanned caesarean after the baby was 'stuck'.</td>
</tr>
<tr>
<td>106</td>
<td>30 year old Croatian woman who lives with her husband, 10 year old daughter and 7 month old baby. She had a planned caesarean due to PTSD following a previous vaginal birth.</td>
</tr>
<tr>
<td>107</td>
<td>38 year old woman who lives with her husband, 4 year old son and 3 month old baby. Her first baby was very premature (28 weeks) and delivered by caesarean under general anaesthetic. She experienced a planned caesarean due to concerns about blood pressure and her prior birth history.</td>
</tr>
<tr>
<td>108</td>
<td>32 year old Pakeha woman who lives with her husband and 3 months old baby. She discovered she was pregnant after experiencing a heart operation, and had a planned caesarean because of this medical history.</td>
</tr>
<tr>
<td>109</td>
<td>39 year old Pakeha woman who lives with her partner and her 11 week old son. She was induced due to her age, and had an unplanned caesarean under general anaesthetic as the baby was distressed.</td>
</tr>
<tr>
<td>110</td>
<td>36 year old NZ Maori woman who lives with her husband and 8 month old baby. She had a planned caesarean due to breech presentation.</td>
</tr>
<tr>
<td>111</td>
<td>32 year old Pakeha woman who lives with her husband and 4 month old baby. Her labour was induced and she had an unplanned caesarean due to 'failure to progress'.</td>
</tr>
<tr>
<td>112</td>
<td>33 year old Cook Island woman who lives with her husband, 3 ½ year old daughter and 8 week old baby. She had a caesarean for her first daughter due to failure to progress, and had a planned caesarean for this birth due to her medical history and concerns this baby would be larger than her first.</td>
</tr>
<tr>
<td>113</td>
<td>33 year old Pakeha woman who lives with her husband and 8 week old son. She experienced a planned caesarean due to breech presentation.</td>
</tr>
<tr>
<td>114</td>
<td>34 year old Pakeha woman who lives with her husband and 13 week old baby. She was induced into labour due to concerns regarding baby growth, and experienced an unplanned caesarean due to failure to progress.</td>
</tr>
<tr>
<td>115</td>
<td>34 year old Pakeha woman who lives with her husband and 12 week old daughter. She had a planned caesarean due to breech presentation.</td>
</tr>
<tr>
<td>Participant 116</td>
<td>116 is a 35 year old Pakeha woman who lives with her 9 year old daughter and 10 month old baby. She attempted a VBAC, but had an unplanned caesarean due to failure to progress.</td>
</tr>
<tr>
<td>Participant 117</td>
<td>117 is a 30 year old Pakeha woman who lives with her husband and 5 month baby boy. She was induced as she was overdue, and had an unplanned caesarean due to failure to progress.</td>
</tr>
<tr>
<td>Participant 118</td>
<td>118 is a 19 year old Samoan woman who lives with her parents, 2 sisters and 3 nephews and nieces. She had an unplanned caesarean due to failure to progress.</td>
</tr>
<tr>
<td>Participant 119</td>
<td>119 is a 39 year old Pakeha woman who lives with her husband and three children: 3 ½, 2, and 3 months. She had a planned caesarean due to medical history (2 previous caesareans) and posterior presentation.</td>
</tr>
<tr>
<td>Participant 120</td>
<td>120 is a 33 year old Pakeha woman who lives with her husband and 10 week old son. She had an unplanned caesarean due to 'failure to progress'.</td>
</tr>
<tr>
<td>Participant 121</td>
<td>121 is a 34 year old Pakeha woman who lives with her husband, 2 ½ year old daughter, 2 ½ week old baby and is currently living in her parent's house. She had a planned caesarean due to previous medical history and issues of gestational diabetes.</td>
</tr>
<tr>
<td>Participant 122</td>
<td>122 is a 31 year old Pakeha woman who lives with her partner and 4 month old daughter. She had an unplanned caesarean due to the baby in distress.</td>
</tr>
<tr>
<td>Participant 123</td>
<td>123 is 35 year old Pakeha woman who lives with her partner and 3 month old daughter. She was induced following concerns about the baby, and had an unplanned caesarean due to failure to progress.</td>
</tr>
<tr>
<td>Participant 124</td>
<td>124 is a 31 year old Pakeha woman who lives with her husband and 8 month old son. She was induced as was overdue, and had an unplanned caesarean due to failure to progress.</td>
</tr>
<tr>
<td>Participant 125</td>
<td>125 is a 35 year old Chinese NZer woman who lives with her husband, 2 year old, and 10 week old daughter. She had a planned caesarean due to a 4th degree tear following her previous vaginal delivery.</td>
</tr>
<tr>
<td>Participant 126</td>
<td>126 is a 30 year old Tongan woman who lives with her husband, 17 month son and 7 week old baby. She was induced due to concerns regarding the baby's growth, and had an unplanned caesarean due to failure to progress.</td>
</tr>
<tr>
<td>Participant 127</td>
<td>127 is a 39 year old Pakeha woman who lives with her husband and 6 month old twins. She had a planned caesarean due to pre-eclampsia late in pregnancy.</td>
</tr>
<tr>
<td>Participant 128</td>
<td>128 is a 40 year old Pakeha woman who lives with her 4 month old daughter. She had a planned caesarean due to fibroids blocking her cervix.</td>
</tr>
<tr>
<td>Participant 129</td>
<td>129 is a 31 year old Indian woman who lives with her husband, 6 year old daughter, 4 year old daughter, and 10 month old son. She had an unplanned caesarean due to a breech presentation which was discovered in labour.</td>
</tr>
<tr>
<td>Participant 130</td>
<td>130 is a 34 year old Pakeha woman who lives with her husband and 3 month old son. She had a planned caesarean due to pre-clampsia, and her baby was born at 29 weeks.</td>
</tr>
<tr>
<td>Participant 131</td>
<td>131 is a 32 year old Pakeha woman who lives with her husband and 3 month old daughter. She had a planned caesarean due to developing toxemia late in pregnancy.</td>
</tr>
<tr>
<td>Participant 132</td>
<td>132 is a 39 year old Pakeha woman who lives with her husband and 7 week old daughter. She had a planned caesarean due to concerns with the baby growth, high BP and maternal age.</td>
</tr>
</tbody>
</table>
APPENDIX I Initial coding list

PREGNANCY
4.1 Birth plan
4.2 Knowledge of c-section
4.3 Planned c-section
4.4 Actual pregnancy
4.5 Expectations for birth

FREE NODES
F 1 Guilt
F 2 Description of baby
F 3 Induction
F 4 Future deliveries (vaginal or c-sctn)
F 7 Unreal or surreal
F 8 LMC (Midwife or obstetrician)
F 9 Anaethetist
F 10 “Too posh to push”
F 11 Medical staff
F 12 Previous birth experience
F 13 Control
F 14 General/Epidural
F 15 Antenatal
F 6 Other comments

LABOUR
3.1 Safety (concern for baby or mother)
3.2 Problem in labour
3.3 Actual labour
3.4 Drugs
3.5 Decision for c-section
3.9 Pain relief
3.12 Support

BREASTFEEDING
7.1 Preplanning
7.3 Immediately after birth
7.3 Experience in hospital
7.4 After the hospital
7.5 Current opinions

THEATRE
5.1 Contact with baby in theatre
5.5 Actual experience of c-section in theatre
5.6 Baby in theatre

AFTER BIRTH
6.1 Recover room
6.3 Baby
6.4 Bonding
6.7 Pain after caesarean
6.10 Pain relief
6.2 Reaction to birth (others)
6.14 Reaction to birth (self)
REFERENCES


Berry, S. (2007). *Too posh to push or too quick to cut. Deconstructing media representations of elective caesarean sections*., Simon Fraser University, Vancouver.


Powell, A., & Davies, H. T. (2001). Qualitative research may be more appropriate. *BMJ (British Medical Journal), 322*(7291), 928.


