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LOST IN THE NORMALITY OF BIRTH

A study in grounded theory
exploring the experiences of mothers
who had
unplanned abdominal surgery
at the time of birth

A thesis presented in partial fulfilment of the requirements
for the degree of Master of Arts in Midwifery
at Massey University

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ABSTRACT

This thesis presents a research study using grounded theory methodology to explore the experiences of women who have unplanned abdominal surgery at the time of childbirth, commonly referred to as casearean section. The intent of this study was to describe, understand and finally encapsulate in a model the personal impact on mothers of unplanned abdominal surgery at the the time of birth, for women who receive care within the current New Zealand maternity services.

Ten participants who had unplanned casearean sections were asked to share their personal experiences during unstructured interviews. The question asked was : *What was it like for you when you had your baby and what does it mean for you now?*

The data analysis in this study shows the experience for these mothers to be very stressful. Coming to terms with a birthing experience that did not meet their expectations, feelings of loss of control, unexpected pain and discomfort, difficulty in nurturing their babies and a great need to experience birth were all revealed. Mothers felt they were not listened to by some midwives and as a result had many unmet needs. Some midwives and health professionals appeared to view the major abdominal surgery that occurred as an alternative method of birthing, often trivialising the impact of the surgery and significance of having a casearean birth for this group of mothers.

The implications for midwives and maternity services providers are broad, including the need for continuity of care and specialist nursing and midwifery care to meet the needs of this small but significant group of mothers and their babies.

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Chapter One: Introduction

Introduction

This grounded theory study is about mothers' experiences of unplanned surgery at the same time as childbirth. The motivation to explore the experience and meaning for birthing mothers who have unplanned major surgery, a caesarean section, came from my personal experience in the clinical setting of a postnatal ward. I entered the room of a young first time mother and her infant who had experienced an unplanned caesarean section seven hours earlier. This woman was distressed, in pain, flushed and crumpled in her bed. The theatre linen which was still under her was blood stained and she still wore a theatre gown. She had not been offered pain relief or a drink and had not been given a wash. Her infant had not been to the breast and was out of her visual range on the other side of the room. As the epidural had not fully worn off the young woman was unable to assist herself to move or to attend to her daughter who was crying. She was alone. She commented that having a baby is supposed to be the greatest thing that could happen to a woman, but this was the worst day of her life; she wished she could die and she didn't feel like a mother or anything else, "just a big failure".

As I cared for this young woman I began to ask myself questions; What has happened here? Why are her physical needs as a surgical client not being met, and where is the midwifery supportive care? Do we really understand the distress for such mothers? What is the real impact of this experience for them and does the type of service we offer meet their needs? My curiosity was awakened, and I became progressively more aware that a woman who has an unplanned caesarean section and not separated from her infant at birth is treated as just another mother with a new baby. They look like any other postnatal women with their infant beside them. Because their wounds and emotional pain are invisible their needs are often overlooked because the focus is on the normal birthing experience and expectations are focussed on women who have had an uncomplicated delivery.

Although there have been studies on the experience of mothers who have caesarean births, none have considered the subject from the viewpoint of women having major surgery at the same time as childbirth. Most studies are not New Zealand based and, since the restructuring of maternity services following the changes to the Nurses Act 1990 has been radical, it is difficult to assess whether findings from previous studies still have relevance to New Zealand midwifery practice, or indeed whether these studies reflect the current experience of this group of mothers in New Zealand.

Aims of this study

The aim of this study was to gain additional knowledge about mothers within New Zealand Maternity Services who have unplanned surgery at the same time as childbirth. An in-depth study was planned to determine the experiences for these mothers and the impact of this upon them within the first six months post-partum.

The study was designed to gain insight into the implications of unplanned surgery for mothers, the health care system and the society in which they are cared for. The study is intended to increase the awareness of the midwife, the maternity services, nursing and midwifery education providers and the community of the impact of having a caesarean section. It is hoped that this may then guide the roles of these groups in the appropriate management and care of mothers during childbirth. The insight was achieved through talking with women who were willing to share the experience with me.

The research question that was asked was: *what happens and what is it really like when unplanned surgery occurs at the same time as childbirth?*

It is generally accepted that every physiological event has the capacity to generate feelings and perceptual reactions in the individuals who are forced to cope with the situation. The process of birth is one of life experience that leads to multiple emotional and perceptual responses (Affonso & Stichler, 1978, p 40).

Planned or unplanned caesarean sections are known to have possible negative implications for women and their partners. This includes risking damage to the

mother's self-esteem and self-concept and a wide range of short and long term effects. Although some ante-natal classes mention the possibility of a caesarean birth, few prepare mothers factually or emotionally for an elective or emergency section and the short and long term care that this requires (Wood, 1992).

The public perception is that caesarean births are just a part of a mother's experience of having a baby. Rarely is it acknowledged that this is also major abdominal surgery similar to a hysterectomy or removal of an ovarian cyst (Grayson, 1995), in both of which women are granted the status of being sick and certain privileges and roles are given. The mother who has given birth is expected to continue with her role as provider of the care for her new born infant and the management and running of her home and family while trying to recover from major surgery. Looking after a newborn baby, getting up at night, and establishing breast feeding are hardly ideal ways to recover from surgery. Caesarean section may be life saving but at other times it is arguable whether a long convalescence is preferable to a long labour. The intention of this study is to uncover the real experience for these mothers as they adjust to surgery, unplanned birth experience and the demands of being a new mother with an infant to care for.

Summary

This chapter has provided the reader with an introduction and overview of this study which explores the experiences of mothers who have unplanned surgery at the same time as birth. The background to this research, and the justification for this present study has been demonstrated. An overview of the structure of the thesis will now be presented.

Chapter Content and Overview

This study is presented under eight chapter headings. A brief outline of the content is given to guide the reader through the research process and to follow the decision making that led to the conclusions that were made.

Chapter One:

Chapter One has introduced the reader to the study. The observations and experience as a midwife in clinical practise which alerted me to question the experiences of mothers who have unplanned abdominal surgery at the time of birth and to further explore these from the mothers perspective have been discussed.

Chapter Two: Use of literature in grounded theory

The second chapter provides the reader with an in-depth background to the use of literature in grounded theory. The justification for the absence of a formal literature review is presented, and the background of the context in which the birthing experience occurs is given.

Chapter Three: The research methodology

This chapter explores the research methodology of grounded theory and its link with symbolic interactionism. The grounded theory research process is discussed. The way in which the methodology was carried out within this research is documented, including the way the mothers were selected, ethical considerations and the trustworthiness of results.

Chapter Four: Experiencing

Chapter Four is the first of three data chapters. In this chapter the construct *needing to experience* is presented including the need to see, the need to labour, and the need to make sense of the experience of birthing - all as revealed by the mothers in this study.

Chapter Five: Nurturing

A further construct of the theory, *nurturing*, is presented under two headings: the need to be nurtured and the need to nurture. The impact on the mothers when these needs were met or not met is discussed, and factors that influenced the need for nurturing for and by the mothers are revealed.

Chapter Six: Miserableness

Presented in this chapter is the construct *distress* that emerged from the data. Three categories of distress emerged in this study: physical, emotional and

intellectual. Factors that contributed to these concepts are presented along with links between them that lead to the overall feeling of miserableness.

Chapter Seven.

This chapter presents a conceptual model “*Lost in the normality of birthing*” which summarises the commonalities and recurring themes within the mothers experiences of having major surgery at the same time as childbirth. This chapter serves to integrate the constructs discussed in chapters 4, 5 and 6.

Chapter Eight.

Chapter Eight provides the reader with a discussion of the implications of this research for midwifery practice. Recommendations for future research are offered and some specific limitations of this study are discussed. A concluding statement about the research is given.

Chapter Two: Literature Review

The Use of Literature in the Grounded Theory Studies

Most research methodologies use an extensive literature review to identify the gaps in knowledge, and to develop hypotheses to test and generate ideas that add to existing theory and knowledge. In the grounded theory study the literature review is an ongoing process that is conducted to fulfil the needs of the analysis (Chenitz & Swanson, 1986). The literature is regarded as a data source. Initially the literature is reviewed to identify the scope, range, intent and type of research that has been done. Following the discovery model the grounded theorist reviews the literature while the data collection analysis goes on. The literature is revisited throughout the research process and is compared to the developing theory as it progresses. The literature reviewed reflects the emergence of codes and theoretical categories. A final literature review is conducted at the end of the analysis and the theory is presented in the context of other work and existing theories on the subject (LoBiondo-Wood & Haber, 1994).

Grounded theory researchers all comment on the limitations of the formal literature review as commonly presented in the research process, but to date the literature has usually been presented separately from the data rather than being treated as an integral part of the analysis. Glaser and Strauss (1967) first raised the concern that the conventional literature review process may distort the field study, but nevertheless a literature review has generally continued to be conducted and presented in the traditional way, even while researchers state that the literature is to be a data source.

Glaser (1992) further developed the argument regarding the use of literature in grounded theory and states

There is a need not to review any of the literature in the substantive area under study. This dictum is bought about by the concern to not contaminate, be constrained by, inhibit, stifle or otherwise impede the researcher's effort to generate categories, their properties, and theoretical codes from the data that truly fit, are relevant and work with received or preconceived concepts that may really not fit, work, or be relevant, but appear to do so momentarily. It is hard enough to generate one's own concepts, without the added burden

of contending with the “rich” derailments provided by the relative literature in the form of conscious or unrecognised assumptions of what ought to be found in the data. (p. 31)

He goes on to say;

Grounded theory is for the discovery of concepts and ideas, not for the testing or replicating of them. Grounded theory must be free from the idea of working on someone else's work or problems. (p. 32)

Glaser acknowledges that this is only so at the beginning of a study. In grounded theory the data is first collected in the field, and then analysed using coding until definite codes and categories begin to emerge. When the theory seems sufficiently grounded in the core variables and in an emerging integration of categories then the researcher begins to review the literature in the substantive field and to relate it to the study in progress.

The researcher by now knows his own categories quite well and cannot be shaken from them. He can only sharpen them by better fitting ideas from literature, not merely by catchy ones. Other integrative connections will surely occur to the researcher as he compares the work to related literature and the contribution to it becomes clear. (Glaser, 1992, p. 33).

Glaser goes on to explain that reading literature in the substantive field becomes faster and the literature can be reviewed quickly for what relates to the emerging theory. The researcher can skip and dip when reading thereby gaining greater volume coverage since he or she now has a clear purpose for covering the field. This approach is quite important given the proliferation of literature - it is far more efficient than reading literature beforehand with no clear notion of its relevance.

Christensen (1990) comments that it is significant that Glaser and Strauss were primarily advocating the use of their methods for sociologists and that the *tabula rasa* ideal cannot be applied to researchers examining their own field. A midwife researcher cannot pretend that there is no background of experience and knowledge, or some familiarity with the literature and the midwifery setting, which in turn influence the research conduct and outcomes. She suggests that

This role has already been examined and the claim made that this dual role is a viable one that can be exercised in a study using grounded theory approach. Therefore the midwifery

researcher while always remaining grounded in the field data and using this as a primary source for the emergent theory, will also acknowledge that the study is grounded within current midwifery knowledge and theory. (p.234)

The methodology chapter will develop the author's decision that grounded theory was the best suited methodology to use for this particular study and justify the adoption of Glaser's (1992) interpretation of grounded theory analysis. When using this interpretation the literature is a data source, not easily separated from the analysis, and must therefore be integrated within the chapters in which data analysis is discussed. Throughout this study it has been necessary to search and critique a wide range of literature, including nursing, midwifery, education, psychiatry and popular literature. This related literature has given insight into the different experiences of mothers having major surgery at the time of childbirth and places their experiences within the context of other literature and data sources on birthing which will become evident within the data analysis.

The remainder of this Chapter will present a discussion, supported by other literature, that will place my research within the context of childbirth and midwifery in New Zealand.

Caesarean Section

Caesarean Section, or abdominal delivery, is the delivery of a baby by means of an incision in the abdominal wall and uterus of the mother. A 10 to 14 cm incision is made in the lower abdominal region, across the narrowest and lowest part of the abdomen. The disadvantage of this incision over a larger incision made higher and vertically is that it does not allow for extension should this be necessary, as in the case of a large baby or difficult fetal position (Ladewig, London & Olds, 1990). The risk of further damage from stretching the wound increases the risk of bleeding and soft tissue damage. A redivac drain¹ attached to a drainage bottle is inserted and in place for 24 hours, during which the mother commonly requires an intravenous line for hydration and administration of medication. There is a urinary catheter in place for several

¹ redivac drain is a vacuum sealed drainage system placed into the abdominal wall layers to remove any excess fluid or blood that may occur post surgery.

hours. The surgery usually is performed in a hospital that has full medical and surgical support services available for the baby and mother.

Maternal mortality is two to four times greater for women undergoing caesarean section than for vaginal births (Rosen, 1989). Although the risk involved in a surgical delivery has been halved in recent years, the fact that twice as many are performed means that the number of mothers at risk remains the same (Pratten, 1990). Major complications may result from haemorrhage, injury to the bladder or intestines, trauma to the ovaries, endometritis, infection of the wound or urinary tract. When compared to a vaginal birth, a caesarean section always poses a greater risk to the baby (Olds et al 1990). As with other types of major abdominal surgery, immediately after the operation the physical care of the mother is most important. The mother needs stabilising in the first hours with a midwife/nurse remaining in close attendance. This involves close monitoring of vital signs, the wound and vaginal bleeding and the mother's general well-being.

The general indications for such a delivery may be either maternal or fetal. Maternal indications are for physical factors, for example uterine dysfunction resulting in failure to progress. Term breech presentations, maternal hypertension, maternal diabetes, placental abnormalities or anatomical deviations are all indicated as reasons for intervention. Fetal indications include when the baby has become distressed or there are fears for the baby's outcome. Rhesus incompatibility, gestational age and size of the baby may place the baby at risk. This may be a very preterm baby or a post term baby or a very large one - over 4500 grams (Oxorn, 1986). If there has been a previous fetal death or damage to the baby in a previous pregnancy abdominal delivery may be indicated. Some of these conditions are obvious prior to delivery and an elective caesarean section is then indicated, but more often there is no prior indication that these conditions are present, or likely to be, and when they arise an emergency or unplanned section results.

The New Zealand situation

The incidence of caesarean sections has risen steady in most developed countries over the last decade. However there is no evidence to support the use of abdominal delivery for many of the common indications. Pearson (1984), a

leading obstetrician, commented that caesarean sections were one of the least controlled clinical experiments that had occurred in medicine.

In New Zealand caesarean sections are the second most frequently occurring surgical procedure performed on women (Linton, Borman & Findlay, 1988).

According to the Health and Selected Morbidity Data of the New Zealand Department of Health, 10% of all births are by caesarean section (1986-1992). However at National Women's Hospital, in the geographical region of this study, the rate was 16.6% in 1991, increasing to 19.6% in 1994 (Auckland Health Care, 1995). This means that one in four births will be by surgical delivery. The high rate may reflect the fact that this hospital is a large base hospital with a high rate of referrals from other units who are not resourced to care for mothers who develop difficulties associated with pregnancy and labour. Therefore the statistic probably does not demonstrate an over-use of surgery at this time. However the overall New Zealand rate of caesarean section is higher than the World Health Organisation recommended rate 10 to 15%(cited Pratten, 1990)

In the last decade there has been a strong move by consumers and midwives towards the de-medicalisation of childbirth and a trend in recognising child birth as a normal, natural part of the life cycle. The midwifery management of pregnancy has moved towards the acceptance of birthing as a natural part of the life cycle and care is focused on the normal birthing experience. Mothers are encouraged to be active participants in the birth process and to be able to care for themselves and their babies from birth and during the early postnatal days. At the other end of the continuum technology has allowed many women who previously would not have conceived or given birth to a live child to do so, thus increasing the chance of surgical or medical intervention.

The use of technology in the routine monitoring of labour has also be examined for its effect on the increasing caesarean rate. The restrictions that technology has placed on the mothers' ability to labour freely and to be unrestricted in how and where they are able to labour has contributed to an increase in intervention rates. The over-use of technology may set up a chain of events that actually creates the conditions requiring a caesarean section. It is difficult to have a well managed labour when one is being clocked on its progress (Kidd, 1990). As well, there will always remain a small percentage of women who will

require an unexpected caesarean section for maternal or fetal distress. These mothers will require supportive skilled surgical nursing and midwifery care.

It is easy for those who work in the area of maternity services to forget that for people without expert knowledge, the realisation of the need for invasive surgery in order to give birth to a child can be a devastating experience (Hillan, 1992). It is also difficult for those that care for women in labour and the postnatal period to support and assist these clients if their own focus of practice is only on the normal. The carer may become deskilled in caring for that group of women which has abdominal surgery at this time. It is therefore important that those who care for this small but significant group understand the experience for the woman and ensure that care and interventions meet their needs. As health professionals midwives can do little in some cases to prevent the need for the intervention, but midwives can do much to ensure that such mothers receive the appropriate care and support that enables them to make sense of the events in a positive way.

Childbirth is a social and personal experience as well as an obstetric event. Hillan (1992) states that

For most women a satisfactory outcome to the pregnancy involves more than the delivery of a healthy baby but takes into account the more subtle processes involved in coming into contact with the health care. (p. 274)

In New Zealand few women appear to view pregnancy and delivery as a biological event that they have no control over, and increasingly they are demanding a more holistic approach to their care and a greater responsibility in decision-making related to the care they receive (Grayson, 1995).

Regardless of their choice of lead care provider mothers will have some care by a midwife. This midwife may be hospital based, in independent practice or working with other professionals. This meeting with the midwife may be planned, with one that the mother has met and actively engaged in her care. Or the meeting with the midwife may be unplanned; the mother will not have met the midwife prior to going into labour or admission to the postnatal ward or discharge from the hospital to community care, so that the 'getting to know you' described by Flint (1986) occurs simultaneously to the need for care. The mother's own needs and plans for the birthing experience may be unknown to

this midwife. Often a woman may be cared for by many midwives as few hospitals are able to offer continuity of care (Pairman & Guiland, 1994).

Continuity of care and partnership are central to the philosophy of the New Zealand College of Midwives. The midwife is the person believed best suited to provide continuity of care and midwives should take responsibility for the whole of the normal birth process. There is much debate about what this means. Some see this as very restrictive notion which implies a personal relationship between the mother and only one midwife or doctor. Others see it as the setting up of group practices and teams. As a result there is much division about what midwifery care should or should not be in the New Zealand midwifery profession (Rose, 1995; Churcher, 1995; Clotworthy, 1995). If midwives are unclear about appropriate care and how to deliver it, it is not surprising that mothers are also confused.

Christensen (1990) comments that nursing (midwifery) action is affected by the nature of the health care system and that its mode of operation is mainly prescribed by the resources, practices and beliefs influencing the provision of health care. These resources include beliefs about health and health care as well as about financing, technology and trained personnel and these vary from community to community.

Restructuring of the health care services and the economic restraints that have resulted place pressures upon the services that mothers are able to receive. The Social Security Act of 1938 provided up to 14 days of free hospital care following childbirth but due to economic pressures on the health care system this has slowly been reduced. This provision has now come to mean 14 days of care in hospital or the community. The cost of mothers remaining in hospital after giving birth has resulted in earlier discharge from the postnatal ward. The average stay is now 48 to 72 hours. This places enormous pressure on the midwives to prepare the mother for her role of caring for her baby and herself. Breastfeeding is rarely fully established before leaving the hospital. The focus is now on early discharge rather than on the needs of the mother.

Since the 1990 Nurses Act in New Zealand the range of options for mothers who have normal births has increased, but little has changed for the mother who requires abdominal surgery to give birth to her baby. In Auckland the Caesarean Section Support Group describe the efforts they have made at "trying

to get them (the Area Health Board) to realise that it was major surgery and some kind of assistance for recovery was necessary" (Kidd, 1990). Consideration has moved from a medical perspective to that of an economic one - it is costly to keep mothers in hospital therefore we do not do it (Kilgour, 1990). Currell (1990) suggested that changes in organisations can come about as the result of changed philosophical concepts or from carefully planned research. It is unclear which of these is responsible for the current state of maternity services, which appears from this study not to meet the needs of mothers who have unplanned caesarean sections.

Summary

Caesarean sections are referred to in different ways from other forms of surgery as Oakley (1983) states, " we do not call it surgery or an operation or hysterotomy but use the term 'section' ". The trivialisation of its major surgical aspect may affect the mothers psychosocial and physical morbidity.

A background to issues in New Zealand midwifery and maternity services has been provided, placing the experiences of the mothers in this study in the New Zealand context. There has been no study such as this under taken in the New Zealand setting and few overseas studies have considered caesarean section as unplanned major abdominal surgery at the time of birth.

This chapter has provided the reader with an understanding of the purpose and use of literature when using grounded theory research methodology. Support for including further literature review as part of the data analysis has also been given. The traditional function of the literature review to place the study in context and identify the gaps has been achieved

The chapter following will discuss how this study was conducted.

Chapter Three: Methodology

Introduction

This chapter will discuss the use of grounded theory as a research methodology and its applicability to this midwifery study. The participants and setting will be described first, along with the ethical considerations and process of obtaining informed consent. The method of data collection and analysis will follow, and the chapter will conclude with the development of a conceptual model which encompasses the experiences of the participant mothers who have had major surgery at the time of birth.

Grounded theory

Grounded theory methodology was chosen because it appears to fit the question well and has the most potential for generating understanding of the experience of unplanned abdominal surgery at childbirth and the implications this may have for midwifery practice. Midwives already use participant observation and interviews in their clinical practice on a daily basis; by using this method theory evolves from practice and is therefore directly related to everyday midwifery care (McCormack, 1991). Grounded theory, as one of the qualitative research methodologies, has been well utilised in nursing research because it "offers a systematic method to collect, organise and analyse data from the empirical world of nursing practice" (Chenitz & Swanson, 1986, p. 14).

The methodological approach for this study combines the use of unstructured in-depth interviews for data collection and grounded theory for the analysis. Grounded theory is a qualitative methodology; qualitative analysis means any kind of analysis that produces findings, concepts or hypotheses that are not arrived at by statistical methods (Lo Biondo-Wood & Haber, 1994). Grounded theory allows the researcher to develop a substantive theory that meets the criteria for doing good science; theory, observation, compatibility, generalisability, reproducibility, precision, rigour and verification (Strauss & Corbin, 1990).

Symbolic interaction is the theoretical base for grounded theory. Symbolic interactionists consider the self to be a uniquely human concept which is dynamic, interacts with a social context and evolves over time. Social phenomena, incorporating meanings created from experiences, are the object of the study. Three premises underpin the symbolic-interactionist approach. These are that humans respond towards things as a result of the meanings that those things hold for them, that these meanings result from social interaction with others, and that meanings are formed and reform the interpretive process (Blumer, 1969). Powers and Knapp (1990) believe that the symbolic interactionist tradition holds that the relationship between self and society is an on-going process of symbolic communication, whereby individuals create a social reality. The social psychologist George Herbert Mead is credited with the origins of symbolic interactionism in the early twentieth century. Glaser and Strauss (1967) further developed this systematic approach for generating theories from data and it became known as grounded theory. Glaser and Strauss's purpose was to bridge a perceived gap between theory and research and the undervaluing of qualitative studies - they developed this approach while working in a school of nursing.

Although developed as a sociological tool to investigate interaction in social settings, the grounded theory method is not bound to that discipline. Many researchers have used the method and study the same phenomena from very different perspectives (Strauss & Corbin, 1990). The approach is more than just a method of data analysis; it is an entire philosophy about how to conduct field research. In recent years Glaser and Strauss have evolved the grounded theory method further, but they now take separate and very different views on how to examine the data. Glaser (1992) feels that the logic of grounded theory is to ask three formal questions. They are; what is the chief concern or problem for this group of people, what accounts for the most variation in processing the problem, and to what category or what property of what category does this incident indicate? These questions are asked while constantly comparing incident to incident. Glaser keeps his attention focused on the data to allow the data to tell its own story, so that the theory emerges from it (Morse, 1994).

Glaser (1992) suggests Strauss instead stops at each word and asks, "what if"? Strauss brings to bear every possible contingency that could relate to the data whether it appears in the data or not. This moves away from the original intent

of grounded theory and could result in the data being forced into the researcher's own meaning rather than allowing the theory to emerge. This forcing may leave the participants' meanings behind. In other words it becomes more difficult for the data to tell its own story. For the purposes of this research I have taken the Glaser position on the method used for analysis as I wanted the voices of the mothers to be clearly heard, without my thoughts and ideas moulding the data in any way.

The divergence in analytic guidelines presented by the two grounded theorists provides the opportunity for researchers to choose and adapt analytic techniques in accordance with the many influences, both personal and contextual, that shape grounded theory (Gilmour, 1994). The distinctive aspects of developing grounded theory such as theoretical sampling, constant comparative analysis and theoretical memoing remain unchallenged. These will be further explained in later sections of this chapter.

There have been a number of studies within midwifery that have used grounded theory methodology to provide valuable information for midwifery practitioners. Seldzik (1994) focussed on the mothers' experience in birthing and decision-making. Hillan (1990) combined grounded theory and quantitative methodologies to explore long term and short term morbidity for mothers who had either planned or unplanned caesareans. Bassett-Smith's (1988) research focused on authenticating the experience of childbirth. Beck (1993) developed a substantive theory of postpartum depression using grounded theory, and Patterson, Freese and Goldberg (1990) used grounded theory to explore how women utilised health care during pregnancy.

Midwives appear to be more responsive to information that has direct links with their everyday practice than to theoretical concepts seemingly removed from practice. Grounded theory can also allow for a fresh perspective in a familiar situation (Stern, 1980). This is helpful when researching caesarean section experience as it is not a new area of care for midwives.

The study was planned to explore mothers' experiences in the natural setting with no manipulation of events, experimentation or predetermined hypotheses. The intent was to find out the meaning of the experience from the mothers' perception. There has been greater attention in recent years within midwifery

on gaining understanding of experiences for clients rather than just focusing on the clinical aspects in isolation to the meaning they may have for the client.

The sample

A purposive sample was obtained. This is a non probability sampling strategy in which the researcher selects subjects who are considered to be typical of the population. I selected mothers who had had an unplanned caesarean section in the last six months and had not been separated from their babies after birth. I believed the latter to be important as I wanted to look at the whole birthing experience rather than the experience of birth together with an ill or preterm infant or the mother being medically ill at this time. Unplanned birth was defined as any caesarean section not previously indicated that was performed once labour had started. An approach was made to a new mothers' group in the community and interested mothers were asked to contact me by phone if they would like to be involved. These mothers then approached others who might be interested. This is referred to as snowball sampling (Politt & Hungler, 1991).

Ten mothers participated in this study; five were *prima paras*² and five were *multi paras*³. The mothers in this study had all expected to labour and a vaginal delivery was the outcome assumed. Of the mothers who had experienced caesarean sections during previous labours, each section had been unplanned prior to the birth. There was no indication on any occasion that a vaginal delivery was not possible even with a previous history of caesarean section.

The ages of the mothers were from 24 to 45 years of age. Nine were European and one Maori. Six were from middle class backgrounds and four from lower social economic backgrounds as described by the New Zealand socio-economic index (Elley & Irving, 1976). The birthing and post partum experiences had occurred in a wide variety of settings. These included postnatal experiences in both small maternity units and large base hospitals, but the surgery had always taken place in a large base hospital. The units were in a variety of geographical areas. There was also a variety of primary care givers; independent midwives, family doctors, hospital midwives, doctors and obstetricians.

² *prima para* is a mother having her first baby

³ *multi para* is a mother who has previously given birth.

An added bonus was that several mothers had had previous unplanned caesarean sections; from ten mothers interviewed there was a total of 17 caesarean section experiences. This added a depth and richness to the data that had not been expected.

Ethical Considerations

Prior to commencing this study the research proposal was presented to, discussed with and approved by the members of the Massey University Human Ethics committee. All research requires that the researcher undertake steps to ensure ethical standards. These steps included obtaining informed consent, preventing harm, ensuring anonymity, confidentiality, consideration of legal issues, and identifying areas of conflict. These will now be discussed.

Informed consent

After the participants had contacted me a letter was sent to each of the mothers outlining the research study and the way in which the data were to be collected. Anonymity and confidentiality were explained. The mothers were informed that they could withdraw from the study at any time.

My name and my supervisor's and our contact addresses and phone numbers were given. The mothers were asked to sign a consent form before participating. This explanation of the study and signing of the form occurred prior to the day of the first interview and was not taped. On the day of the taping of the first interview each mother was asked verbally if she still wished to be interviewed. (See appendices for participant information).

Prevention of harm

Likely harm to the mothers was seen to be minimal. A potential risk was that psychological unrest or distress brought about by issues unearthed in the process of interviewing. I had arranged for support services to be available to the mothers should they need to further explore emotional or personal issues that arose during the interviewing. One mother sought this assistance. I explored the area of distress with her and referred her to an appropriate agency which provided ongoing support to resolve her concerns related to the birthing

experience. The mother was pleased to have the opportunity to further clarify these and to deal with previously unresolved issues she had experienced since the birth of her baby.

An area of conflict for me was the distress experienced when listening to the mothers' stories of care received that did not fit with my own beliefs about midwifery practice and the care that I, as a midwife, might have given in the situation that they described. This required my biases to be identified and memoed. Discussion with my supervisor ensured that objectivity was maintained as far as possible.

One of the problems of this kind of research is that, because of the need to become immersed in the data, at times the researcher becomes very emotionally involved. Two of the interviews provoked such an emotional response in me that I was unable to deal with the data while listening to the women's' voices. These two interviews were transcribed by a typist and I was then able to distance myself from the data and to be more objective about the information contained in these interviews. The written word became easier to come to terms with than hearing the women's own voices recount their experiences.

Glaser suggests that one way to distance oneself from this intense involvement is by sorting memos into portable files while watching the television which helps to protect one from taking the decision-making too seriously.

Sorting memos phase is difficult because the analyst either leaves notes all over the house, office and car, or becomes glued to the typewriter for hours on end. At this point it is wise to remember that the separation between creativity and insanity constitutes a flimsy barrier. (Stern & Moxelt, 1984 p.379)

Distress or harm to the researcher appears to be an area that ethics committees sometimes overlook. The committee which reviewed my proposal did not ask me about potential harm to myself, or what strategies I had to deal with these. My supervisor's role in dealing with these emotional reactions was invaluable.

Anonymity of the participants

Within the study there were no details that could identify the mothers, carers or the places where they had had the birthing experience. The mothers are

referred to only by interview number - no personal names or geographical locations or institutions names are used.

Confidentiality

The data was stored safely, with only myself and my supervisor having access to the tapes and transcriptions, although some secretarial help was required with transcribing of the tapes - a signed non-disclosure agreement was sought from that person before transcribing began. Interviews were coded with only myself having access to the code for participant identity. The interview data were stored in a secure, locked filing cabinet and will be kept for five years. The tapes were returned to the mothers.

Legal Issues

The data will remain my property, and the tapes the property of the mothers. Additional consent will need to be sought in the future from the mothers to use the data in any way that differs from that agreed on the consent form. No copyright issue is envisaged. Formal written consent was sought prior to the interviews. A copy of the transcription of the tape was given to each participant on completion, to keep as a record of the conversation that took place and to confirm accuracy

Conflicts of interest

I did not anticipate that there would be any areas of concern regarding conflict of interest. However one area of conflict that did occur was the concern about the care givers and care received in one particular unit that caused the mothers much distress. It appeared to me that staff in this area were practising in a manner that was regarded unsafe according to the Midwifery Standards of Practise. I referred this to my research supervisor for guidance and agreed solutions. It was resolved that mothers had not given me permission for this information to be given to the administrators of this unit so I was unable to do this.

Data Collection

Data collection took place over several months, with the interviews taking place in each mother's home. Most interviews took about an hour to an hour and a half. After confirming consent, I asked the mothers to describe their experience of having an unplanned caesarean section. The question was simply "What was it like for you when you had your baby and what does this experience mean for you now?" The interviews were not structured and I only sought clarification or more in-depth explanations on issues raised by the mothers so as to maximise their opportunities to describe their experiences. I was surprised at how open and eager the mothers were to talk about the experience. They appeared to be pleased to talk to someone to whom their story really mattered. All the interviews were audio taped, transcribed and reviewed by the mothers to detect errors or omissions that may have occurred during the transcribing.

The literature was regarded as a data source for comparison and the literature was reviewed throughout the data analysis stages.

Data Analysis

A major feature of grounded theory is that data collection and analysis occur at the same time. Grounded theory analysis requires systematic and detailed process. A key aspect of this involves the interrelationship between the collection of data and constant comparative analysis and coding. The process is called theoretical sampling. This is

...data collection for generating theory whereby the analyst jointly collects, codes and analyses his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges. (Glaser and Strauss, 1967, p. 45)

The process reflects the ongoing emergence of the theory during data collection and analysis. Theoretical sampling gives the research process flexibility, thus allowing the researcher to explore new dimensions of the research topic as they arise.

Constant comparative analysis is the name given to the activity of examining the data word by word, line by line, breaking it down into discrete parts. Each

part is then compared for similarities and differences, and coding then follows. Using the Glaser approach to grounded theory analysis overall patterns within the data are looked for, instead of focusing on words and phrases and sentences that seem significant.

Strauss' method neglects the integrative effect of constantly adjusting meanings as categories and their properties emerge, get connected by theoretical codes, and get sorted into theory that explains the main resolving action in a substantive area. (Glaser, 1992, p. 55)

Coding is a key part of the process. As data are received a system of substantive coding is applied. This is so called because they codify the substance of the data. Codes are developed from the concepts reflected in the data and named. Three levels of categories were used. Level one looked for codes in the words that the participants used. For example words and phrases such as *emotional distress, felt awful, hurt, uncomfortable, terrible, lack of control, felt like a failure, not in control, alone* were coded as physical distress and intellectual distress. Level two moved the data to a more abstract level. Codes used at this level are called categories. Categories are codes clustered together according to obvious fit as seen in the following example. Some of the level one codes were defined, developed and integrated into the level two categories- for example, three level one codes became one category called *miserableness* (Figure 1, p 23). The third and final level of coding involved developing theoretical constructs, which add theoretical meaning and scope to the substantive theory (Glaser, 1992). The level three theoretical construct came from all the level two categories and was named *unidentified needs in birthing*. The substantive theory that finally emerged was *Lost in the Normality of Birthing*. This process is illustrated in Figure 2 (p. 24). Refer to Chapter Seven for further clarification and discussion of the substantive theory.

During the coding and comparing of categories ideas generated were re-coded into memos. Memos are an important part of coding - they are the ideas and theories and their relationships that occur to the researcher during coding. Memos are kept separate from the data and regularly sorted and referred to. Glaser and Strauss regard this process of thinking and reflecting on the data and categories as important because "the root of sources of all significant theorising are the sensitive insights of the observer himself" (1967, p. 251).

<i>Informant Data</i>	<i>Level 1 Codes</i>	<i>Level 2 Codes</i>
Exhausted, painful, revolting, awful.	Physical distress	
Terrible, negative, failure of support.	Emotional distress	MISERABLENESS
Lack of privacy violation, overwhelmed, alone, upset, feel like a failure, abnormal, lack of control, no information, unprepared.	Intellectual distress	
No-one asked where you were at, no-one cared where I was at.	Needing consideration	
I just needed someone to, needed to be (listened to, heard).	Needing support	NEEDING TO BE
They come and go, it helps to have familiar people, didn't know who they were,	Needing continuity	NURTURED
I felt unsafe because, they could have made a mistake.	Needing to be safe	
Couldn't look at her, see what sex, wanted to (care, b/f, wash, hold) her.	Urge to explore baby	WANTING TO
Wanted to get it right, needed to be in touch, be together.	Urge to care for baby	NURTURE
I cried when we were separated, not being close, not being together.	Need to be with baby	
Need to feel the contractions, need to (labour, to do, to try).	Wanting to trial	
Wanting to birth naturally, wanting to see the birth.	Wanting to see	EXPERIENCING
Never understood, needed to understand what happened.	Wanting to understand	BIRTHING
Need to make sense.	Wanting to make sense	

FIGURE 1 Partial audit trial - Connections of basic constructs with data

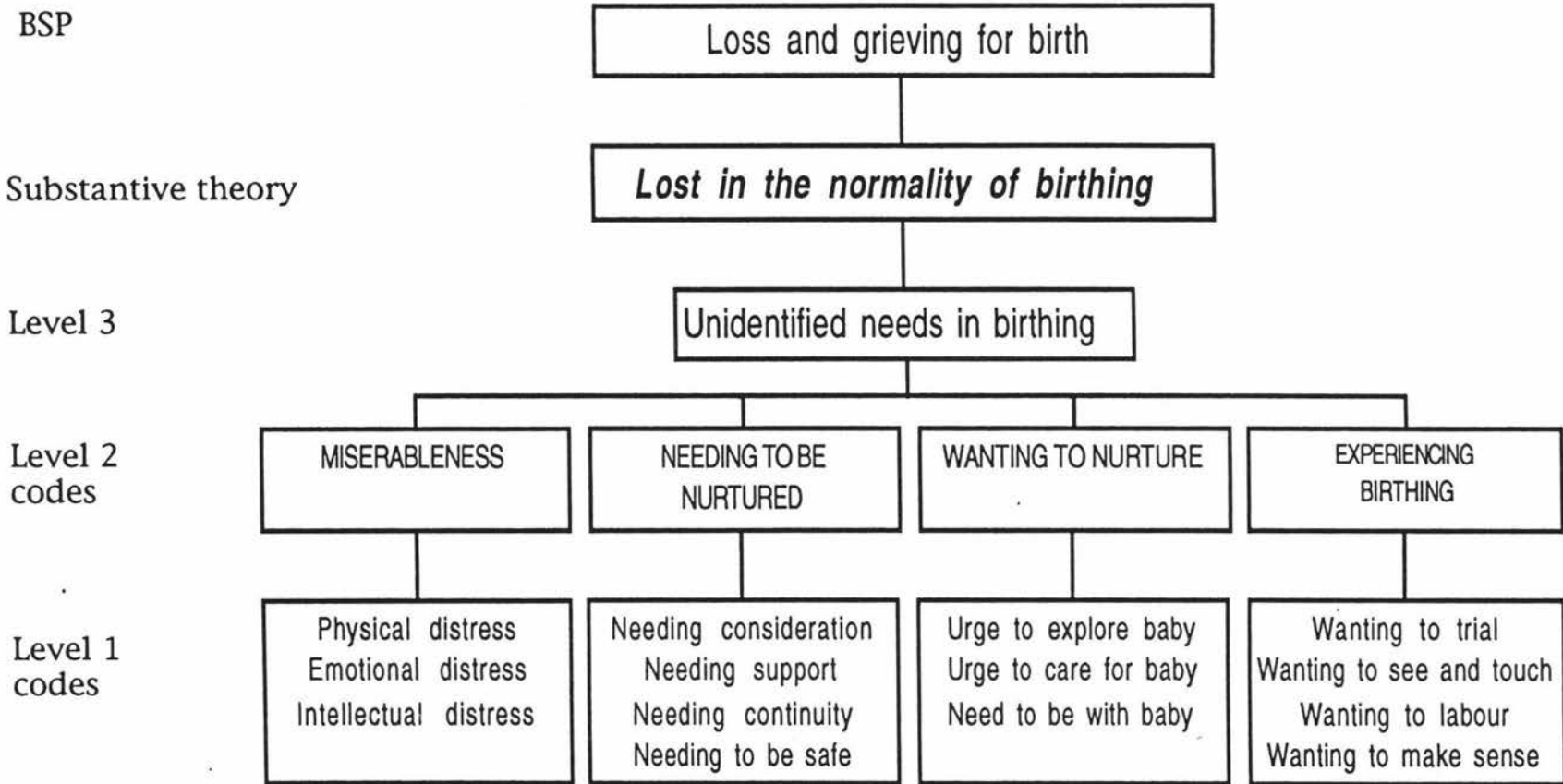


Figure 2: Lost in the Normality of Birth

By sorting these memos about the categories, the core variable or basic social psychological problem(s) (BSP) emerged. Theoretical saturation occurred when additional data analysis failed to uncover any new ideas about developing substantive theory. The substantive theory developed in this study is discussed in Chapter Seven.

I chose not to use a computer program to analyse the data for core variables. Computers are very helpful but have no sensitivity to the mothers' social world or understanding of the meaning behind such statements as "I feel a failure", "It became their baby" or "It was just awful". Instead I used a systematic sorting process using plastic snap-top bags. The transcripts were cut and sorted into codes. The level one codes went into small bags and were labelled. There were initially 62 which then collapsed into 19 larger bags. At the level two stage these then collapsed into 6 bags and further refined to 4. At level three these four larger bags (*miserableness, need to be nurtured, wanting to be nurtured and experiencing birth*) became one, *unidentified needs*. This last bag containing all categories and codes so far developed were further collapsed into one overall theory, *Lost in the normality of birthing* (see Fig 2). The emerging basic social problem that emerged was *grief and loss*. Chapter Seven further discusses and develops this theory.

Grounded theory requires the researcher to remain sensitive and close to the data. This requires creativity and an intuitive sense (Becker, 1993). Manual coding allowed me to remain immersed in the data and to use creativity and continual questioning of the data throughout the process.

Trustworthiness of Results

The factors involved in establishing trustworthiness in the findings of qualitative data have been described by several workers as credibility, confirmability, transferability, saturation, dependability and meaning in context (Leininger, 1994; Lincoln & Guba, 1985).

Credibility

Leininger (1994) refers to credibility as the confidence one can have in the truth of the findings. Similarly Lincoln and Guba (1985) describe credibility as

the truth of findings as judged by the participants and others within the discipline from which the subject is being studied.

This was established by sharing the data analysis with midwifery colleagues who recognised their own experiences in their care of mothers who have unplanned surgery at the time of birth. In some cases they identified similar situations and emotions from their own birthing experiences.

Confirmability

Confirmability is referred to as the repeated participatory and documented evidence observed or obtained from primary informants' sources (Leininger, 1994) or, as Sandelowski (1986, p. 30) puts forward the idea ;

A qualitative study is confirmable when it presents such faithful descriptions or interpretations of a human experience that the people having the experience would immediately recognise it from those descriptions or interpretations as their own.

The mothers reviewed the data, interpretations and conclusions. The mothers then validated that the substantive theory reflected clearly their experience of having unplanned major abdominal surgery at the time of childbirth.

Transferability

This refers to whether particular findings from a qualitative study can be transferred to another similar context or situation (Leininger, 1994). The goal of qualitative research is not to produce generalisation but rather in-depth understanding and knowledge of a particular phenomenon. Transferability focuses on the general similarities of the findings under similar environmental conditions, contexts, or circumstances. This was achieved by providing thick, rich slices of data to make transferability judgments possible for future researchers wishing to apply these findings to other possible situations.

Saturation

Saturation occurs when the researcher has done an exhaustive exploration of what is being studied and the researcher finds no further explanation or interpretation or description of the information gathered. Leininger (1994) refers to this as

The full taking in of occurrences or full immersion into the phenomena in order to know it fully. Informants often state “There is no more to tell as I have said all I know about the topic.” (p. 106)

After the tenth interview there appeared to be little new data emerging and redundancies and duplication of similar ideas, meanings and experiences and descriptions were starting to occur, and so at this point it was decided to stop collecting data. The time frame of this study did not allow for further data collection which may have confirmed this more clearly and enhanced the findings.

Dependability and Stability

Becker (1993, p. 44) states

Dependability is the stability of the findings over time and confirmability, objectivity or neutrality of the data is confirmed.

This was achieved by having a doctorally prepared supervisor experienced in the methodology follow an audit trail that I used for data analysis, starting with the transcriptions and ending with the substantive theory. I also kept a diary in which I recorded personal experiences and reactions to data collection to prevent personal biases from interfering with data analysis. Agreement was reached between myself and my supervisor at each stage of the data analysis. Members of a graduate research group and a co-supervisor provided valuable assistance to me in challenging and clarifying my ideas and biases throughout.

Meaning in-context

This was referred to as

data that has become understandable within holistic contexts or special referent meaning to informants or people studied in different or similar environmental contexts. (Leininger 1994, p. 105)

Review of the literature occurred simultaneously with the data analysis and revealed that some of the categories had been identified in this study had also appeared as similar themes or fragments of other writings and research on the subject.

Conclusion

This chapter has examined grounded theory as a research methodology which is appropriate for this study. Grounded theory is a highly systematic research approach for the collection and analysis of data for the purpose of generating explanatory theory. The data were collected in the natural everyday world. They were used to further the understanding of the social and psychological phenomena of mothers who have unplanned abdominal surgery at the same time as childbirth.

This chapter has outlined the process of this research, including ethical considerations, access to participants, and the data analysis process. The following three chapters will present the data and its development into a conceptual model.

Data

In the following chapters data, concurrent analysis and discussion are presented. As both literature and the researcher's field notes are identified as data within ground theory methodology, these are also integrated.

In the next three chapters the results of this study will be presented under the four level-two categories that led to the construct *Lost in the normality of birthing* (Fig 1,p.24) and further discussion on the substantive theory is presented in Chapter 7.

Key to Abbreviations

The abbreviations and fonts used in the subsequent chapters have the following meanings.

...	pause
(..)	material edited
<i>interview 1</i>	the interview number of the participant
Bold	emphasis, eg loud speech
plain	researcher's comment or questions
<i>italics</i>	speech of participants
Times font	direct quotes

The participants are known through out the study by interview number rather than name.

'Birthing experience' refers to the all experiences that occurred through out the total time of birthing, including the antenatal, delivery and postnatal periods.

Chapter Four: Experiencing

Experiencing

For mothers who had unplanned caesarean sections the need to experience birth was clearly important. This chapter describes the need to experience as felt by these mothers. To experience in this context was seen as being actively involved in the birth and the knowing about birth came from participation in all stages of birth. The mothers did not seem to be so concerned about the postpartum experience as they were about the intrapartum experience.

The need to experience the process of birth physically and emotionally is as important as the end result having a child of one's own. However there are several other issues that seem important. In her book "Woman to Mother", Vangie Bergum (1989) discusses how women tell each other about their childbirth experience and about their feelings, and how they reminisce about labour and delivery. It is through this talking that many women come to realise that they may have missed an important event in their lives. Mothers in this study commented often on the need to fully experience birth. One mother summed up these feelings well when she said;

I think doctors need to realise that women have babies (in order) to experience a birth; it's not just to have a baby at the end. Interview 2.

The need to experience birthing for the mothers in this study was described as the need to see, the need to feel and the need to have a trial of labour.

The need to see

This was particularly important to mothers who had a previous caesarean section and for mothers who had not seen their infant immediately at the moment of birth.

I would really like to see this baby actually born, I said that is the one thing that I haven't done, so that was great as soon as you know they

used the forceps and got his head out and they propped me up enough to actually see the rest of him being born and wow! gosh he was long and I actually didn't even look at what sex he was. It really surprised me you know I wondered if that's the first thing you do. I scanned him several times before I suddenly thought, Oh! what is it? and I went oh it is a boy and I burst into tears and I thought how lovely. Interview 1.

OK sure there was people around him (baby was on the heat table in theatre) and from time to time I couldn't see him but had seen him and I had touched him, but I knew he was there. And I think that is really important too if you can see the baby. I mean for days with my other baby I thought she was just their baby from out of it somewhere, not me. Interview 4

It was in 1972 that Klaus and Kendall's research suggested that extended contact between the baby and the mother at birth assists in better mothering. This research demonstrated the importance of the first postpartum hours and days for the development of maternal attachment. Feelings of detachment from their babies was also common amongst mothers in my study.

The need to labour

Most mothers felt the need to labour. It was important to them that they had the opportunity to see if they could progress to a natural birth: allowing the baby to choose its birthday was important. Even when a caesarean section was found to be necessary mothers felt that having gone into labour naturally meant that their bodies were ready to give birth.

I was quite happy, I actually enjoyed ... yeah I actually felt you know I was giving birth in every sense even though I had been labouring for hours and getting nowhere. Despite the pain I was birthing. I had initiated the birth. Interview 5

My doctor couldn't understand that I was prepared to labour again they thought that I was out of my tree. I think people have to start talking to women, listening to women and they will find that yes you know they are prepared to trial. You are never going to get caesarean rates down if

you are offering them willy nilly - it just doesn't work that way and instead of encouraging women they are blocking you at every corner. Interview 3.

A lot of them were quite negative, you know in the aspect of don't be ridiculous or let's be sensible. You know you have had two other sections let's be realistic and book this one in. It did sort of get you down that approach. I just needed to be sure it was not going to be possible to have a normal birth. Interview 6.

I needed to make sure I couldn't have the baby on my own. In other words it is very important for women to labour and have babies on their own if they can. It is not the mechanics of having a baby it is the emotional, yes it's all important. The birth experience was lovely just wonderful, magic. I actually laboured this time, felt the contractions, the pain, I experienced the spa bath, the different position we had been taught, I had a wonderful labour, I felt I had him myself though it was a caesar it was so ... I can't really explain it. Interview 2.

The need to experience I noted in my field notes.

What is it that drives woman to need to experience the pain of childbirth? So far mothers have all talked passionately about wanting, needing to feel birth in many ways. It seems that you haven't given birth unless you have felt the pain. What is it about the many facets of this pain that is important? Pain of childbirth cannot be explained - is it that birth pain brings with it life and is therefore positive and desired, to say I felt it I have birthed, or is it that other pain is seen as distress and possible danger and to be avoided?

The need to touch and feel

Mothers talked often about the blood and messiness of birth as being important - part of their perception of what a normal birth was like. Somehow this needed to be seen and felt as a confirmation that birth had taken place.

... it was a real thing for me I actually wanted to see a bit of goo. Interview 3.

I had actually looked forward to seeing the blood and all the gunk [laughter] because that's what I had imagine birth to be like. The baby all wet and messy not all clean and wrapped up like he was. It didn't feel like he had been born, rather he was taken. Interview 9

... I felt I had missed something. Others I know talk about you know when the waters broke, the wetness, the warmth, the unexpectedness of it, all the uckey messiness. Sounds funny but I missed that... somehow that's what birthing is about. It's like it's OK to make a mess in birth, you don't have to be apologising. It's Nature's mess. Interview 10

The need to make sense

Part of this experiencing was the need to make sense of the events and in doing so to touch innermost emotions and feelings. There was little opportunity to do this. Bergum (1989) suggests that part of transformation from women to mother is in experiencing and understanding the birth. From the field notes the following was noted.

There appears to be an implied if not always clearly articulated need for the mothers to talk about their birth experience. It has become clear that mothers need to make sense of the experience so they can get on with the business of mothering. Many seem to be blocked in their transformation to motherhood, still engulfed in the events that took place weeks and months ago. The eagerness to talk openly about their inner most feelings allowed them to revisit the birthing experience and to make sense of what had happened. It seemed that the interview was the first time someone had really listened after the birth, no-one had revisited events and talked through why things had been how they were.

Three mothers articulated this well when they said

It is going to be interesting what memories this brings up. I've never really talked about it before. It seems that no one really wanted to hear about it. Yet it seems important to have someone care enough to listen. Being heard what it really was like for me is important. Interview 2

I don't remember anyone talking to me about you know that is how it went or how are you feeling about it or anything. I really did need to

talk about it and still do. I mean I have talked about it with friends, they must be sick of hearing. I really need to talk about with some one who was there, someone who knows, who understands. I have never really had the opportunity to go through it in a meaningful way. Interview 5.

Flint (1986) talks of the midwife going to see the mother the next day to talk through the experience and tell how it was. The mother needs to be told what happened, the sequence of the events, why they happened and exactly how the baby was born, what it did, what it looked like and to allow time for the mother to ask the unanswered questions.

It is three months now since she was born. There just seems to be large pieces missing. I keep having flash backs, and I think Oh God what happened then, I can't remember. People who visited me say I remember this and that about the baby when she was born. She was like this ...We both felt so awful that we didn't take any photos and now I can't remember what she was like but others can. Even my husband can't remember the sequence of events really clearly. Interview 10

Rubin (1984) discusses the stages of the postnatal period the mothers need to pass through, the first being the taking-in stage where the mother is focused on herself. The mother has a need to repeatedly discuss her experiences in labour and birth, in order to integrate her experiences. This appears to be even more so for the mother who needs to come to terms with the loss of the birthing experience she had wanted, or to adjust to the loss of her fantasised child and accept the child she has just born.

Most of the mothers in this study appear not to have passed through this stage of taking in and are still needing to make sense of the experience. Their ability to get on with mothering - the taking hold stage as described by Rubin(1984), appears to have been inhibited.

Part of the problem is you're not prepared for the suddenness of it all. One minute you're having a normal labour then you're not everything becomes so different and you're not prepared, aware or something - you can't take it all in. It's really important to be able to talk it through, make sense of it. It just plays on your mind, why this why that, why,

why, why - you can't get past it. I really wish someone had sat down and sort of relived it with me, putting in all the correct bits. I still feel angry that I don't really know what happened and if it will be like that again. I don't know if I feel like I had a birth or an operation. Is there a difference? I don't know. I have done neither before. Interview 9.

Even though everything was cruisy, things were really going well. Everything was completely under control, the girls had been to see me, I had the visitors I wanted, but there was this other feeling of ... I have had an operation here, not just a baby. That was a bit scary because no one really mentioned that. Sometimes I had to look at the wound to be sure that's what I was really feeling. Interview 3

Clarifying the confusion and allowing women the opportunity to reconstruct their experiences and express feelings is an important and often neglected part of facilitating adjustment in the postpartum period (Mercer, 1985). Nicholson (1990) asks whether birth fits better into a model of loss and bereavement than into an accumulation of life events. Although having a baby is seen not as a loss, the transition to motherhood is often negative although temporary. It is the change in life circumstances that is not acknowledged. Mothers at this time have many role changes. They now must adapt to being a mother, a parent and a family with the responsibility that this brings. Their relationship with their spouse and extended family member also undergoes a change as all adapt to their new role as grandparents, aunts and uncles. Often their financial situation changes as many mothers move from the paid workforce either temporarily or permanently. Women who are used to having social interactions and being in close contact with others throughout the day now find they must adjust to being at home where they have limited opportunity for adult company and have no social networking in place.

To have experienced birthing offers possibilities of self-knowledge, knowledge of their own limitations and capabilities, knowledge of new life as a mother and, as Bergum's (1989) research points out, the opportunity to know the place of women in the mysterious cycle of human life and death and rebirth.

As women give birth to children they in a sense birth themselves. These mothers, who had unplanned abdominal surgery and an unplanned birthing

experience, appear to have a greater need than women who have 'normal births' to have experienced birth in a way that gives meaning to them and which fits their expectations, and those of others close to them, of what it is to birth.

Conclusions

This chapter has examined the construct *experiencing*. The need to know about birthing by experiencing has been shown to be very important. Experiencing included the need to feel, to see, to touch and to participate. Of significant importance for mothers was the need to make sense of the birthing experience, particularly when it did not match their expectations. Failure to do so made it difficult for them to move on to the next stage of becoming a mother.

Chapter Five: Nurturing

In this next chapter the level-two construct to emerge from the data, *nurturing*, will be presented. This concerns the caring, supporting, nourishing, nursing, sustaining and tending to the mother and her baby by the people around her. It also includes the acts that mothers perform to care for and protect their newborn babies.

Mothers in this study cited their own need to be nurtured and the overwhelming need to nurture their newborn baby. The need for mothers to feel cared for during childbirth has been described by Percival (1994) and Rossi (1973) as intense. For the mother who has had major surgery at the time of birth the need to be nurtured is very important. The major abdominal surgery required to give birth results in physical restrictions which inhibit mothers' abilities to care for their babies, as discussed later.

Nurturing will be discussed under the *need to be nurtured and the need to nurture*, as described by the participants in this study.

The need to be nurtured

Mothers in this study described the intense need to be cared for and supported during the birthing experience. Emergency or unplanned surgery at the time of birth will inevitably influence the amount of contact that the mother has with her infant within the first hours after delivery, and maternal reactions are likely to be affected by the stress associated with surgery and the events that led up to that time. These may occur on top of an exhausting and long labour (Ball, 1987).

Postnatal care is as important as the actual delivery part of the child-bearing process, but has been given the lowest priority. Hillan (1992) in her study found that postnatal care was the area most frequently criticised. Her study group looked at 50 low-risk women whose babies had been delivered by unplanned caesarean section and were matched with a control group of 50 women who delivered vaginally. A structured interview was conducted during the hospital stay. These mothers were also sent questionnaires at 3 months and another

semi-structured interview was conducted at 6 months. Some of the responses were cross-referenced to their clinical records. Of the group 44% felt they did not get enough sleep or adequate rest, compared with 24% of the control group. A frequently mentioned complaint was lack of support from midwives in the ward and in the community after discharge from hospital. This was particularly so for the group which has undergone unplanned caesarean section .

A further stress relating to this time is that parenthood arrives abruptly. Unlike most work roles the birth of a child is not followed by a gradual period of learning or taking on of responsibility. In recent times shorter hospital stays have exacerbated this situation. Parenthood may seem instinctive and instantly fulfilling, but the reality of is usually quite different from what new mothers have imagined or been led to believe (Rossi, 1973). As a new mother adjusts to her new role during the postpartum period her support needs are high. The mother's perception of care available to her may in turn affect her ability to give support, care and attention to her child. The support the new mother receives must affirm her in her new role by providing feedback that verifies her successes in mothering (Percival, 1994).

In this present study mothers needed to feel that they were being seen as individuals with unique needs, needs that were different from other mothers who had given birth. They had had surgery, had lost the birth they desired and had a new baby to care for.

I was an individual and this was my unique experience rather than being thought of just another caesarean and just another baby. Even after my second one I remember feeling that, or getting the feeling that, oh this woman's a second caesarean so she knows what it is all about basically and OK, it was my second, but it was a whole totally different situation to my first and in that retrospect I wish somebody had talked to me and listened to me. Interview 7

I needed to know that if I wasn't happy with something the midwife would take it on herself to make it right, that she would phone, she would ask, she would look out for me. I was not capable of doing that. Interview 6.

You need that close care, you need to be pampered and nursed right through, you need someone just being there, holding your hand, being there for you. Interview 6.

I think after the baby, you sort of do really need a lot of help really. You can't do it all like all others (mothers who had birth naturally) even if you want to. Interview 5.

During labour mothers all said that they seemed to have lots of people around them although, as discussed later, this was not always seen as an advantage. During the postpartum period they felt the opposite occurred. Following the birth mothers were very much left alone to fend for themselves with their babies, and so they felt they were unsupported and uncared for. The role of her closest and dearest then became that of visitors, and the physical care became the domain of the professional.

I must have asked four or five nurses if I could have a different bed. I had one of those beds that you actually had to have steps to climb up into bed. It was just too much trouble to get me some steps. It was hard with the wound and everything to get into bed so I stayed in the chair until my husband came to help me. Interview 2

... like I had sore nipples and I asked them to give me something and they didn't have anything on the ward, they did nothing. Interview 7

It was so shabby and horrible up on those wards. They put the baby near me but not where I could actually reach over and pull her out. I had the bell but I had to ring it lots of times before they came, that was awful. One day I discovered that it didn't work so of course they never came. Interview 8

After I had the baby I was stuck in my room, I could not get out of bed. I would try and get up and I was passing out and I couldn't figure out what was wrong. I couldn't stand up and go to the bathroom on my own. I really needed some one to help me, someone to tell me it was normal and it would be OK. Interview 5

They were saying they were going to do this and that, and that they would come back, but they never did. Interview 6

They told my husband to go home after I got to the postnatal room. It was late at night and I was put in a room by myself with the baby. I could not get at her and I could not move because of the epidural and thought God what do I do? They just disappeared and it was on my own. I couldn't go to sleep in case she needed something. It was just so isolating and scary. Interview 9.

Donely (1993) discusses the need for mothers following any type of birth to have a loving supportive family to enable them to cope with the intense years of breastfeeding, sleep deprivation and child raising. The beginnings of this support should start in the immediate hours after birth with people of the mother's choice able to be there with her. Yet so often the family are asked to leave after the mother's admission to the postnatal ward and the woman is left with strangers.

Some mothers found that staff levels were very low, which meant the nursing staff were very busy, so making it difficult for the women to receive the care they felt they needed. They did not see the staff as not wanting to care and support them, but rather felt the nurses had too many other women to look after. As a result the fact that they had had surgery as well as a baby was overlooked, leaving them feeling they were just another mother with a baby to look after.

... they were just so busy ... They had so much on and so many other women coming in with babies that um ... they didn't have time to attend to you and I needed it. I was getting really stressed out. It scared me to think because they were running around so much that if they administered medication or anything they could easily slip up. You could see they were short staffed they were just running the whole time. Interview 8.

I had one really good midwife but she was so good that she was in demand she was ... everyone's ... and could only give me minimal care. Interview 7

I felt like when you get home I haven't got a buzzer so you know I wanted to do it my self ... It was very hard the first time because you can't get ... getting in and out of bed is just a nightmare really. I didn't get any help although I did want to do it myself anyway, but also needed help. Interview 4.

Raphael (1991) comments that availability of professional help is curtailed in many hospitals where cuts have led to staff shortages. Overworked nurses and midwives are less able to attend to the psychological needs (and I would add the physical needs) of new mothers, when they themselves feel like busy mothers at the beck and call of their own charges. She goes on to suggest that nurse dissatisfaction can colour the crucial emotional experience of these early days, leaving them feeling wretchedly inadequate as mothers or aggrieved in their subjective sense of having been bossed around or disregarded.

Perceptions of being unsupported when they left hospital were also reported by mothers in this study. They saw themselves as being alone and having to cope without supportive care by family or professionals. As these mothers put it....

I didn't feel wonderfully supported by him [partner], not that I blame him for that. I don't think he knew what to do. I didn't feel particularly confident, my partner wasn't confident, I had no relatives here and basically had to deal with everything on my own. I remember actually feeling all I really wanted was somebody to come and make a cup of tea and there was nobody. Interview 5.

Yeah ... just to be able to pick up the phone and say look you know I could really use someone just to take the baby for half an hour, maybe even an hour, because I just can't pick the baby up again. It is really hard. To be honest I really think when a woman has a caesarean you need someone to just come in and let you rest without having to worry. Interview 1.

I came home to basically nothing - my husband couldn't take time off. I suppose in the end you do cope and you do manage because you have to, but you feel just dreadful. Interview 3.

Continuity of care

Within the midwifery literature there is a recent awareness of the importance of mothers having familiar people caring for them during the birthing experience (Flint, 1986; Page, 1988; Oakley, 1989; Guilliland, 1990; Flint & Poulengris, 1987). In this study mothers expressed the need for continuity of care very clearly, both explicitly and in general terms.

I was down there for so long I kept seeing these shifts come and go and I didn't find that helpful. I mean I would have the people on the shift, and generally I remember them as being helpful and supportive and then they would change and you would sort of have to go through all again, you know where you were at et cetera. I remember the last shift when M was born I didn't get on with her [the midwife] for some reason, I don't know if I was tired or what or whether it was her, but I was past the stage of trying to get it right. Interview 3

Having familiar people around obviously makes it easier for you. If I had gone into hospital and not known who was looking after me it would have been really different. Interview 7.

I felt that I wish that I had the same people all the way through so that you knew what was coming and who was there ... That was the only thing I wish had been there from the start. There is no point in having all different faces every time. It is nice to have that one person from the word go, to go through it all and you feel more at ease then you can express yourself better or whatever, talk about what you want, where you are at, a lot better. Interview 4

Within the literature the focus for continuity of care has been on care for mothers by the midwife (Flint, 1990). However mothers also said that continuity of care was important, not just from midwives but from any professionals involved in their care.

With this one I had been with the surgeon who had seen me in the whole pregnancy, she knew something about me, about my needs and expectation and that made a big difference. Knowing who was going to do what was important. That's what I felt good about, all that There was no continuity of care. Even with my doctor I did not see her until 6 weeks after the birth. There was no one stable person. I would prefer now to have an independent midwife. Interview 5.

Mothers in this study revealed that when they had continuity of care from known care givers they had a more positive regard for the care they received and indeed the whole birthing experience. Mothers appreciated being praised, understood, empathised with and their decisions respected. They felt that their "nurse"⁴ understood them and they had built up a rapport that was missing if they had a variety of carers.

Mothers particularly liked having nurses/midwives help them with their own needs as a new mother, both physical and emotional. Mothers found it helpful to have feedback and support that affirmed them in their new role and appreciated the opportunity to rest or be given encouragement to look to after themselves.

My midwife encouraging me meant so much more to me, which seems really strange. I don't know why. Just because she does it all the time and I felt she was closer to me than he [husband] was, you know at times, which was really strange because we are extremely close. Interview 8

My midwife and I had sort of come quite close throughout the time and this is what I think I liked so much about having one person, not a doctor and being a female too and a woman who had been through it...she said is there anything I could do to help and I said will you stay

⁴ "Nurse" was the generic term that mothers used to describe the care giver. Mostly no distinction was made between midwife and nurse.

with me and she said yes. So she stayed right through the whole thing [caesarean section] and actually took the photos and everything.

Interview 6.

The hospital midwives referred to by mothers as helpful were also the ones that paid attention to their needs at the time and made them feel supported.

I missed a couple of my hospital appointments so she sent a midwife out to me, and picked me up and that sort of stuff and when I did go in out of the blue she didn't growl at me or anything. She just took me in there for six hours, doing all the things they would have done if I had been coming all the time ... She was real nice. Interview 7

They took all the bits and pieces out⁵ and ... It was just that initial getting out of bed I really dreaded that, but the midwife who did it was fantastic, she you know had the bed that went right down low and she held my feet, supported my feet as well, and then she said to me how to move my arm, which did for some reason help. It seemed so easy to get out of bed. It was painful but she gave me some pain relief first and you know we went to the shower and she was just there with me. Interview 1

They weren't there all the time but the midwives would come back and check on me, see how I was going. They were just so supportive of me. Probably because I had had a bad experience last time and I let them know that I had, and I think that helped. They were all so supportive. It was just the team of doctors they were just totally unfeeling you know. I was not a person, I had no feelings it seemed, to them. Interview 6.

The most consistently supportive person named by the mothers was the anaesthetist. Nearly all the mothers in this study commented on how cared for and supported they felt by the anaesthetist. These mothers summed up the feelings well:

⁵ "bits and pieces" referred to drainage tubing, urinary catheters and intravenous lines.

Yeah he talked to us and we found it easy. He told us step by step what was happening and everything and he was quite humorous at times and sort of laughed and kept us quite happy. So it was really nice having him there and he held my hand explained to my husband what was going on. He even held the baby beside by head so I could put one arm around her and see her. He was so caring. Interview 8

He was great after the baby was born. I couldn't see her and she wasn't crying and I thought Oh my God what is happening but he must of seen my face, and he then explained blow by blow what they were doing and then when they had finished working on her and when it was OK he said to my husband to go over and see what they were doing. He got them to bring the baby over so I could see her. Interview 5

However mothers found the hospital care lacked continuity and independent care was disrupted when the decision to have a caesarean section was made. The midwife or family doctor was required to hand over care at this time to the hospital team, leaving them feeling alone. These two mothers put it like this;

This person that you had got to know so well, trusted so much, needed so much, who knew what it is you wanted, your hopes, your fears was suddenly told that is it - off you go, surplus to requirements. She may not be able to do the section but you sure needed her, not a bunch of strangers to care for you. You sort of felt they didn't think she was good enough. It didn't feel nice at all. You felt very vulnerable and isolated. Someone needs to sort that out. Interview 9.

On the postnatal ward it was like grand central station, a different person every eight hours. It seemed like they never read anything about me. They didn't seem to know who I was or what had happened. One nurse didn't even know I had a caesarean section and got really snappy when I asked her to help me pick the baby up and things like that. Interview 10.

The postnatal visiting by the midwife or plunket nurse was seen by the mothers as an important source of continuity of support and care for themselves.

I did get home and then my independent midwife did come. She tapped right in it was great ... That same face you knew, you had started a relationship and she came and did all my visits, checked my wound and stuff like that. Interview 8

My plunket nurse was actually really good. I think she probably had a scraper and picked me up off the floor and said you can do it. You are going to succeed. Nothing to do with the caesarean, just being a new mother and you can do this and I am going to get you there. She never once criticised anything that I did. She was quite a key role in support for myself and my inner self in coming right. Interview 3.

For one mother her distress at the lack of nurturing and care received for herself during the hospital experience made her quite distressed and unable to accept help after discharge.

I was so distraught I refused a midwife and they never sent a district nurse out. I suppose they never thought of it, I just never thought of it until a month ago. I thought I never had any one to see me, my wound or the baby. So I mean it was a recipe just waiting to happen. Interview 1

The feelings described by mothers of not having their need to be cared for and nurtured met in many ways contributed to their general feeling of miserableness and to their negative views of their birth experience long after the event.

Mercer (1978) comments on the lack of emphasis on the postnatal period and criticised a society that on one hand exalts motherhood, but on the other hand abandons the inexperienced, isolated and weakened young mother to the none-too-tender mercies of her child and expects that she will by instinct know what to do.

Wanting to nurture

The need to nurture the baby was also seen as very important to the mother's in this present study mothers. Neuman wrote

To nourish and protect, to keep warm and to hold fast - these are the functions in which the elementary character of the feminine operates in relation to the child, and here again this relation is the basis of the woman's own transformation (1955, p. 89).

All mothers in this study felt in some way they that had failed at giving birth and they needed to succeed in mothering. There was an overwhelming need to acknowledge the baby was theirs, and to perform the tasks of caring for their baby. This was often made difficult, as discussed in Chapter Six, because of physical difficulties related to the surgery. Mothers needed the midwives to give them assistance to meet these needs.

Yeah, well you know, because I wasn't competent myself I felt that everything I had to put on her I did need help with, so I had to ring the bell two or three times ... They were just running the whole time because they were attending to other women and their babies. So they couldn't really help me. Interview 7

I wanted to do it but I don't know how her nappies stayed on because I was thinking, Oh God! how do I do this? You just sort of just do it. You get along and you do because if you leave them no-one else is going to do it for you. It was also painful with the wound and all that to do these things. Interview 8

Like I said, I think because I am an experienced mother they just left me to do it. My baby didn't get bathed for two days and I didn't particularly like that very much. J [the partner] had to hunt a nurse down to help me bath her because I couldn't. Yes she was like that for two days. A bit poor really. Interview 6.

When mothers received help and assistance with the skills they needed to nurture their baby they felt positive and able to cope. The mothers in this study

all said that being able to breastfeed their babies was important. There were several reasons given as being important - the need to provide the best nutrition for the baby, the need to succeed because they had failed at the birth and the need to be close to their baby.

I really wanted to breast feed. I stuck to my guns and I am still breastfeeding [6 mths], I achieved something I wanted about having my baby, the one thing I can do they can't take away from me. Interview 1

I was really determined to try and breast feed this tiny weeny little baby, which was a shock to start with after the surgery. Interview 9

I had been tearful and such like but I was actually feeling good that the breast feeding was going well, because as I say breastfeeding was an important issue for me. Interview 5.

I had not given my baby the birth I wanted, but I was going to give him the best nutrition I could. Interview 10.

Mothers who are able to breast feed during the first hour after birth have a much higher success rate than do mothers for whom breast feeding has been delayed. This is particularly so for the caesarean section mother (Fawcett, 1985). According to other studies (Chalmers et al., 1989) there is no significant difference in the breast feeding rates between mothers following vaginal delivery and following caesarean section even after six weeks. All mothers commented on how soon they were able to put the baby to the breast. There appeared to be a wide variation in when this occurred. Some were able to do this immediately in the recovery room while for others it was hours later.

According to studies by Simkin (1995) pethidine levels in babies show that traces can be found in saliva up to 48 hours post delivery. These babies are seen to have poor suck co-ordination. This is particularly so for infants when pethidine was given via an epidural catheter as with caesarean section surgery. There is much debate about the effect that anaesthetics administered for caesarean

section may have on breast milk (Samuel, 1991). Some of the difficulties mothers experienced may have been related to this factor rather than to timing

After birth the woman's third blood mystery occurs: the transformation of blood into birth. The ability of the women to nourish is something to be cherished. It is important to the child and to the mother - it ties the mother to the child in necessary ways (Neuman, 1955, p. 102)

The need to nurture as described by Neuman was certainly supported by the mothers in this study.

However, confusing advice and lack of breast feeding policy within the postnatal wards in this study was unhelpful and undermined the mothers ability to nurture her baby. This has been well documented in literature (Aubach & Reardon, 1993; Lawrence, 1994; Ford & Mitchell, 1995) as the major reason for mothers giving up breast feeding, yet mothers in this study still reported this as a major area of concern for them. One mother describes her difficulties clearly;

I really wanted to breast feed but it was just so confusing. They rammed the baby on the breast. He was a big baby and it was so hard to hold him and so painful on my stomach. Every person told me something different. So I would do that then the next one came and said do that, and then they would say why are you doing that? They didn't listen to me when I said it hurts to hold the baby to feed, they just said you have to feed the baby, or you will have to give the bottle or you won't be able to breast feed for three days. Someone wrote in my chart that I was not prepared to listen or take advice - I was but everyone was different. It was just so unsupporting and confusing and so difficult, especially after the section whenever they move you made hurt. I got so distressed that I discharged myself and the doctors were saying I wasn't well enough to go home. When I got home I had my midwife who told me what to do it was so much easier to cope with just one person telling you what to do. Why they don't have set protocols or policies that everyone follows seems really silly and so hard for the mothers. Especially mothers who have had caesareans. Interview 9.

Much of the anger expressed by this mother reflected a reaction to the importance of her nourishing and life giving abilities that were being under valued by others.

One of the difficulties experienced by mothers having a caesarean section is that their babies are more separated easily from them at birth. This separation may not be clearly seen as such. The babies may not be removed from the room but are often physically away from the parents. They are taken to the heat table on the other side of the room out of eye contact and physical reach. It is not possible for the baby to be put on the mother's abdomen or chest when born and the initial exploration and discovery of the sex of the baby is denied. Mothers were usually told the sex of the infant they had. Even if the baby is well at birth, while the surgery is in progress it is very difficult for the mother to see her baby, to visually explore and touch her baby. The baby is often first held and cuddled by others. The partner is the main person who holds the baby after the staff have carried out the immediate assessment and care required. Mothers felt that not being able to do this, getting to know the baby, was very distressing and had long term effects.

One mother described it like this

When I first saw B she was booted and bonneted and beautiful but to me she was the ugliest thing I had seen. It took me weeks to love her, because of the state she was in. Interview 2

Touching, seeing and holding was described as an important part of getting to know, bonding with the baby and being able to nurture. Older puts it like this

.... There are two special times they both relate to those few moments when the head is emerging and the body is still in the womb, when touch is a particularly powerful connector between parents and the child. The second is that reaching out of hands towards the new born - it is its welcome into the world. The crazy hyper-grasping need to touch the new born is not limited to one woman. It is not limited to humans. It is an important part of all births [1982, p. 23].

Women in this study felt it was very difficult to carry out this very important act of birth, reaching out ,holding when their babies were born by a surgical intervention.

Conclusion

This chapter has presented the construct *nurturing*. This has been further clarified as the need to be nurtured and the need to be able to nurture the baby. To feel cared for and to have empathetic people around who listen and focus on the mother seems to be very important to the mothers who had a caesarean section birth. Staff that were able to demonstrate this caring were clearly remembered as making a difference. Mothers talked of the great need they had to touch, explore, initiate feeding and not be separated from their babies. Much of the negative feelings spoken of by women in this study resulted from a perceived lack of nurturing for themselves and an inability to meet the strong urge to nurture their baby well.

In the following chapter the final construct to emerge from the data, *miserableness*, will be presented.

Chapter Six: Miserableness

The mothers in this study expressed negative experiences of emotional, physical and thought patterns that gave them a feeling of *miserableness*, the final construct discovered in this study. Miserableness resulted both from causes within the woman and from external circumstances related to others. In this context miserableness was taken to mean feelings described by the mothers that included despondency, dejection, depression, distress, unhappiness, wretchedness, lack of control and lack of knowledge. External factors were seen as attitudes of health care workers and lack of awareness and understanding by professionals and society that also affected the experience of these mothers.

The intense feelings of miserableness arose from three broad domains: physical, emotional and intellectual distress and issues of control.

Physical Distress

Physical distress was perceived by all the mothers as a major concern; this distress was almost always expressed as pain. The term 'pain' did not have a clear common meaning but seemed to vary in intensity from severe pain to feelings of discomfort. Pain, when experienced during labour and in the immediate post partum, was a subjective response. Pain was expressed as both negative and positive depending on when it occurred during the birthing experience.

Pain during labour was expected and a reality for most women. Although pain was not wanted, the mothers felt it was important not to have pain relief, both for the baby's well-being and in order to be able to birth naturally. Pain was seen as something that one coped with as best one could.

... they actually offered me pain relief and I actually didn't have any. I didn't want it I just had gas. I knew it would not be pleasant. I had been labouring for gosh, 10 hours ... it was just killing me but I still felt good, I was not ready to give in. Interview 2

I really felt positive about the pain, I mean it was really painful because the baby's head was going nowhere but it was positive. Interview 3

However one mother who had five previous normal births welcomed all and any pain relief available.

The whole thing was better than any of the deliveries I ever had. It was the epidural ... the whole thing. Interview 6.

Most mothers used a variety of alternative pain management strategies such as the spa bath, breathing and visualisation.

I kept complaining of back ache ... so she [the midwife] suggested the spa bath ... so in I went ... what I did was during the contractions I let myself float to the top and then sort of sink back down and that helped. I would have said I was in there for about a half an hour but my husband reckoned it was more like three hours. Interview 6

Vaginal examinations were seen by mothers as distressing, ranging from uncomfortable to very painful. These two mothers commented:

... actually it was really quite painful when they examined me without anything [pain relief]. Interview 8.

They never waited until the contractions had stopped, they just you know, did it. It seemed like once they thought I might need a section everyone that came in had to stick their hand up. It was as if they did not believe the last person. It was really awful I felt like a turkey being stuffed. It was so painful, uncomfortable and embarrassing for me and for my husband. Interview 9

None of the mothers felt that pain was an expected part of the postnatal experience. Most expected and could rationalise the distress of the pain during labour but not in the days following the birth. There was an expectation that the pain would finish with the birth and when this did not happen there was great distress.

I just about hit the roof it was just, it was totally indescribable. I could not describe that kind of pain, it was terrible. Interview 5.

I just remember it was actually a real bad experience. I just remember the pain ... It was extremely painful. The pain just never went away. Interview 3.

The pain was related to movement and discomfort along the wound. The drip was painful and uncomfortable, which made holding the baby difficult. Mothers felt there was an expectation that they had to get up to provide total care for the baby and this added to the discomfort.

I felt really sorry for myself, I really did, I was in pain. I could hardly manage to lift the baby up and do everything I had to do for him. Interview 6.

Pain and discomfort from the surgery cause much misery to mothers who have had a caesarean section. Rubin (1984) reported as problematic the discomfort from pain along the incision line, the turning from side to side and general movement in the bed and difficulty handling the infant with pressure on the wound when in contact with the mother, but did not adequately express the intensity of pain and discomfort expressed by these women. Fawcett (1985) reported nausea and vomiting, feelings of dizziness and faintness in the first 24 hours as contributing to the discomfort felt by mothers. Tulman and Fawcett (1988) believed that caesarean section women take considerably longer than vaginal birthing mothers to restore their functioning ability. For several mothers the discomfort continued well after discharge from hospital, but there is little in the literature that acknowledges this. In Hillan's (1990) study 35% of the women still did not feel back to normal at 6 months, with 28% feeling less healthy 12 months later. The women in her study described a wide range of physical discomfort and complaints that persisted for up to three months. Two mothers in my study commented six months after the surgery :

.....uncomfortableness I feel, because it is not complete pain, it was just general uncomfortableness when standing at the change table, when standing at the bench, when doing something or when I scratch myself it hurts- that is uncomfortable. Interview 5.

Just walking hurts a lot, hanging out the washing, bending up and down getting out of the car, carrying the car seat, pram etc is all uncomfortable and exhausting. Interview 2

How these mothers dealt with the pain varied with each experience. Those who had previous caesarean experiences were clear that they needed to manage the pain rather than be consumed by it as had been the case with their other experiences. All stated in different ways that they felt the pain was not managed well by the hospital staff. Little pain relief was offered and its effectiveness was variable.

According to McCaffery (1978) patients are the only ones who know what they feel and when they feel it - pain is whatever the experiencing person says it is and exists when ever they say it does. Within the literature reporting of less than desirable pain management is common, although there appears to be no difficulty with the prescribing of pain relief (Madjar, 1992). Bonica (1980) claims that for many patients in acute medical and surgical settings receiving otherwise sophisticated professional care, pain may be inadequately managed. Bonica suggests that this inadequate management may take several forms. The pain may be ignored, or when new technology is employed often the impact has not been thought about and unconsidered about pain may result. Pain may also be ignored or underrated when inadequate knowledge, erroneous assumptions and unfounded fears guide clinical practice.

A further suggested reason for poor pain management is the low priority in some clinical settings to the giving of medication (Madjar, 1992). In the present study all mothers had to ask for pain relief and they felt there was a general reluctance on the part of midwives and nurses to give intramuscular pain relief after the first day. Some felt that they were not given effective relief once the epidural wore off. Mothers said how they went from feeling nothing with the epidural to the full intensity of pain some hours after delivery. The physical distress caused by poorly managed pain contributed to the physical miserableness felt by most mothers. If these mothers were in a surgical setting having had a hysterectomy, a similar type of surgery, they would be managed very differently. Senior nurse managers say their hospital stays would be on an average 5 to 7 days. Such women would receive analgesia via a patient

controlled intravenous pump for 48 hours and they would never be considered capable of under taking care for a baby or other dependent relative. In contrast, mothers in this study had an average stay of 4 days, received minimal pain relief and were expected within 24 hours to be mobilised and caring fully for their babies day and night.

One mother who had a previous section said

They told me it was charted [pain relief] and as soon as I started to feel a niggle I would ask. They would give me pethidine and panadol at the same time ... with that I actually just felt like I had a tummy ache, I felt I had a hundred sit ups but I didn't have that dreadful pain ... it didn't sort of surround me I felt on top. Interview 5.

Another commented

I had been on pain relief for a while [day 3] they said I should come off it ... I was a bit nervous about it, they gave me some panadol to carry in my pocket but I noticed they put a comment on my chart about being up tight about coming off pain relief ... If you had a c'section and came off pain relief you would be nervous too. Interview 4

First-time mothers spoke in a negative way of the effects of pain relief, and those who had previous births also stated they wanted to do without pain relief to avoid the side effects that contributed to their physical discomforts.

I started to vomit ... at first I didn't like it, sort of you got high very quickly and I felt like, you know, you had drunk too much and you start to spin and I really did not like that feeling. Interview 6

It made me feel very detached from reality, like looking at your self from far. I was not part of it, my head did not belong to my body it was looking at yourself from afar. Interview 2

All mothers in this study had an epidural anaesthetic for the surgery. All but one found this to be very acceptable form of pain relief. However the actual procedure of inserting the epidural catheter they found increased their discomfort at the time. The curling up into a ball with a large pregnant

abdomen was very painful and uncomfortable. The inability to move or control body movement was expressed as distressing and unexpected...

I mean you know you want to be awake for when your baby is born and that, but it was ... it was terrible. I had no control and I felt heavy and when I went up to the ward I felt my body was crooked and I said to P [husband] can you straighten me up and he said I can't, you are so heavy, like I was a hunk of ... sack of potatoes ... it felt really awful that way. Interview 6

... I had not realised that you got the shakes I thought it was just a reaction to everything else that was going on it was really awful ... They could have told me that. Interview 2

Several mothers chose complementary pain relief such as acupuncture and homoeopathics. For these mothers this appeared to work really well. Their pain was relieved or at least made bearable, they suffered no side effects and they felt more able to mobilise. For others medication induced feelings of discomfort, for example nausea and drowsiness. Some mothers felt they had to just put up with the pain.

... I felt I would have to just sort of bear the pain and just have panadol to sort of ease me over ... Injection wise I thought no I should rather sort of roll with the pain and just sort of ride on top of it. I was breastfeeding and thought it could affect the baby. Interview 4.

Much of the physical discomfort mothers described came from such basic activities as trying to get out of bed. The beds were often too high and no foot stools were available to prevent stretching and pulling on the wound. The chairs were not comfortable to sit in. It was uncomfortable to walk, stand up straight, cough, sneeze, laugh, hold the baby or pick the baby up. The sides of the babies cots were at the level of the wound causing pressure which made bathing and changing nappies very uncomfortable.

You keep your bed so low so you can get in and out with your caesarean and then the light on the panel is half way up the wall, which you can't reach. It is really hard you just want to reach out for them, [the baby]

and feed them in bed really, but you can't it is so hard to get up and down. Interview 2

Other symptoms of physical distress that women remembered were those of exhaustion, tiredness and sleeplessness. These are all well documented in the literature related to normal childbirth but appeared to be more intense for mothers who have to cope with the added stress of surgery. (Hillan, 1990). Most mothers had laboured for many hours prior to abdominal surgery and were tired, distressed and exhausted prior to undergoing the emergency surgery. Their exhaustion continued into the postnatal period.

... getting up to care for him, was exhausting, just by the time I had showered in the morning I really, really couldn't do it, I was too exhausted. Interview 4.

I couldn't believe how tired I was after just a few hours of being up and moving around. I hadn't even done anything and I just had to get back to bed. Interview 6

It was really weird I would think right I will get up and have a shower and bath the baby, because I really wanted to do that and I think they felt you should ... but I could not manage to do both without a rest. I had to sit down, some days I had to lie down I thought I was going to faint. I could not believe the feeling of exhaustion and that seemed to be there for days. It seemed like weeks actually. Interview 9.

The typical events of pregnancy and delivery result in many mothers feeling tired and exhausted with multiple discomforts. Both Tulman and Fawcett (1988) and Hillan (1990) suggest that this is even more so for caesarean mothers, who having had major abdominal surgery, must then cope with this along with the normally described discomforts of birthing and adjustment to motherhood and parenting. This was substantiated in this study.

Emotional Distress

Emotional distress in this context relates to the intense feelings and emotional reactions mothers felt during the birthing experience. All women expressed considerable negative emotion. The emotional aspects of mothers' birthing experience has been reported as being mainly centred around the labour experience (Sledzik, 1994). In this study the interviews revealed that while this was so, the early postpartum experience was also a very intense period of emotional reaction and mothers remembered this more clearly than the labour. This emotional reaction in the early postpartum period is not well described within the literature. The common responses described by the mothers in this study were anger, grief, fearfulness, depression, disappointment, despair and aloneness.

I can't decide if the pain was emotional or physical, I was depressed and disillusioned and alone. Interview 5.

I was just so angry and frustrated and so peeved off at everything that had gone wrong. Interview 2.

I thought that I would have this wonderful feeling and I didn't.. just nothing. Interview 5.

....but I was just so upset I didn't want to see anyone and I wanted to be alone. Interview 3.

....and somewhere in the midst of all this out came my baby and I certainly don't remember any wonderful feelings of wow! this is wonderful I am a mother or anything. Interview 4.

I never felt so low honestly I felt like I wanted to jump out the window, I just couldn't cope with the visitors. Everything about it felt wrong. It was meant to be the most happiest time in my life, I just felt so low I could have just walked out in front of a bus. Interview 2.

I had a lot of anger and grief to work through after his birth. It had a disastrous effect on my marriage. Interview 1

For some women the decision to have the caesarean section gave feelings of relief that it was all going to be over.

Pleased as punched I was I just don't like the normal delivery. I was really frightened of it actually. Sometimes ... I think that I might have caused something to make me have a caesarean you know. Because you can do things with your mind. Interview 7

I was just relieved that it was not going to go on and on. I was just so exhausted and pleased to let some else take over. Interview 6

Funny I actually felt quite scared the idea of a caesarean, although on the other hand I was relieved to .. That it was finally going to be over. Interview 7

Most mothers expressed relief that the infant was safe and well. While not wanting to give away the opportunity to birth naturally they were terrified that the baby would be harmed or that they would lose the baby. This was often the factor that made them to agree to the surgery. Paul (1994) summed up the feelings well when she stated:

We wanted so much to do what was best for the baby and I wanted it for myself (a natural birth). As a woman birth is the one thing that is so natural in your life. (p. 6)

Disappointment about the sex of the baby being different from what had been expected was also expressed, coupled with disappointment at not having had a natural birth. There was a general feeling that something had been lost.

When it was a little girl, just everything was gone, just the excitement of having our first baby, it all just sunk away. It was as if to say thank God its all over and the baby was healthy. Some people get very emotional and cry and all that sort of thing, but nothing like that it was all gone. Interview 8

You know when you watch a video of a birth, someone you don't even know being born you get quite emotional, but somehow you don't have the same emotion when it is a caesarean I don't think as when they are

born naturally. I think you miss out a little on that. There is not a lot of choice. Interview 6

The experience was just awful, which is a shame because its well it just seems sad to say it was awful. Looking back now [6 months later] I think I was probably, I was depressed afterwards but either I didn't recognise it, or didn't want to recognise it ... because I certainly do remember, I don't know how long or whatever but you know feeling ... crying, feeling Oh God what is this all about and other people saying how wonderful it is having a new baby and I was thinking how awful.

Interview 5.

It is not until a few weeks later that you sort of think, you feel quite robbed really, I don't know if I want to go through a labour according to what some people say, but I mean people go through labour and then at the end they have a result, but for me they just wheel you down to theatre and "wwwwhhhh" there is your baby ... its sort of computerised you know sort of "dit dit dit".[mechanised process]

Interview 8

Several mothers expressed negative feelings about the invasion of their privacy and the exposure of their bodies to others. Comments by these two mothers expressed these feelings well.

I mean as a 20 year old to have all those men standing around my bed to do the internal as it were, to see how far I had managed to get was so daunting ... I came away with feelings that I still have today. It was more like gang rape, total violation on my body and my husband felt similar. I am actually a private person and not into a lot of people being around me at times like that and I was just, it was just a shock to be treated like that. Interview 2. (crying).

You could have been having an examination or anything. They just bowled in ... you felt like your privacy was gone.. That was really horrible that was the worst, that one part was really bad. Interview 8

These intense feelings of personal intrusion reflect those of Wood (1992), who in describing her experience suggested that in many respects the feelings she experienced during and after her caesarean section were the same as those she had experienced as a rape survivor.

The emotional feelings stirred up by the process of giving birth by unplanned caesarean section continued well after discharge. Mothers experienced the same reactions as any new parent - sleep deprivation, exhaustion, adjusting to becoming a parent and the worry of caring for a baby were all cited and are consistent with the literature. Wood (1992) again confronts the negative emotional effects which caesarean sections can entail for women and suggests that the emotional trauma felt by women after the experience are so profound and lasting that they are like unseen scars. In some studies (Thune-Larsen & Moller- Pederson, 1988) specific factors in the mother's childbirth experience have been shown to relate to postpartum emotional disturbances. Recovering from major abdominal surgery makes this period in the mother's life one of even more intense emotional reactions as she comes to terms physically and psychologically.

....it's not pleasant for a lot of women, it's not nice, its as scary as hell and then you have got this baby that cries ... She cried a lot and I didn't get much sleep. I mean how do you know why it is crying nobody has told you how to take the batteries out. Interview 2.

I could have really got depressed, I mean everything was there, the recipe was all put into place, I actually sat there at different times and thought I could be depressed ... but I thought no I am not ... but I think I was really, but I couldn't tell anyone how awful I felt about the whole experience. Interview 4

The fact that some women may require to deliver differently is not openly discussed among health professionals or lay people. Instead what has developed is dogmatism in supposing that there is a right way to birth and an expectation that all women will birth normally. Although antenatal classes give mothers techniques which may help them to achieve a satisfying birth they sometimes

do not work out in spite of careful preparation because of maternal or fetal problems that may arise. These mothers are then left as they were seen in this study, feeling angry, guilty and disappointed in their own ability to give birth naturally. Women and society need to be well aware of all the ways of birthing that may occur and accept them all. Whatever the mode of delivery the mother has given birth to her baby, the term 'natural' or normal birth should be I believe be omitted. As Axon (1995, p. 12) put it

our socio-cultural norms are out of 'sync' with the 'real' norms for women in childbirth.

This appears to be so for women in this current study.

Intellectual Distress

Intellectual distress was taken to include the thought processes that mothers remembered as occurring during the birthing experience. These resulted from internal thought patterns and from external factors such as health professional's attitudes, perceived lack of control and lack of knowledge, and the unexpectedness of the caesarean section. Mothers had obviously thought about the type of birth they wanted and had expectations that this is how it would be yet these wishes and desires were now unfulfilled.

Most women expressed their determination to birth naturally despite the fact that things were starting to go differently.

During Friday the talk of a caesarean came up which I think was probably the first time I heard that I was likely to have one. I was determined that I wasn't going to ... I was going to birth naturally, that is what I was determined to do and that was how I was going to do it. Despite having been in labour now for I don't know how long, physically exhausted and all that. Interview 5.

....that is all I wanted was for the baby to choose when he wanted to be born. I really didn't think it was to much to ask ... I can't see why because I had two sections that it was suddenly a problem. I could not accept the fact that they weren't going to let him choose when he wanted to be born. I had made an informed decision. Interview 2.

....At that stage [fetal distress was diagnosed] I think I was still feeling positive and thinking well you know it will be OK. Interview 6.

One of the commonest thoughts expressed by the women was that of feeling a failure and being abnormal in not being able to give birth naturally.

....I felt so unnatural, I still feel unnatural, I still hate trying to explain how I felt. It was just like I had grown an extra head, this woman that wasn't a woman, you know, the big important event that I could not carry off and I probably never would be able to carry off ... If only some one had said that's OK, you are allowed to have a baby that way, if that is the way you deliver babies then that is fine. Interview 1.

I felt an incredible sense of disappointment and failure. It took me several months to convince myself that I had not failed - that it wasn't meant to be a natural birth. Interview 6.

Stuart and Sundeen (1987) say that it is important to let women know that it is perfectly normal to feel grief and loss of the birth experience. When the birth is not as planned it is a disappointment but not a failure on her behalf, and mothers must hear that from the health professionals.

These feelings of having failed continued into the postnatal period, and the sense of failure was also expressed about breast feeding and ability to care for the infant.

I had failed at the birth and was not going to fail at the breast-feeding. I was going to get something positive out of this. Interview 3.

The mothers were not specifically asked about breastfeeding or caring for the baby, but still it was important for them to comment on them, suggesting that they felt there was a pressure placed by society on them to birth in a particular way. Perhaps they were suggesting that breastfeeding and caring for baby are also socially sanctioned and these are ways to make up for a less than perfect birth. From the field notes the following thoughts were recorded

What is normal birthing, and how do women come to perceive what birth is about? Mothers in this study all commented at some point on their need to birth normally, yet there appears to be no clear definition of a 'normal' birth. Previous generations accepted homebirth as 'normal', later generations accepted babies born in hospital as 'normal'. To name a few, episiotomies, twilight sleep, separation from infants, long hospital stays. Fathers not present and artificial feeding are all practices that have at various times been seen to be part of the right, proper way or 'normal' way to birth. It is not that long ago that maternal or infant deaths were not an unexpected part of birthing, yet today in New Zealand society these are very unusual and an unexpected outcome of 'normal birth'. Indeed in some countries the rate of maternal and infant mortality is still a common outcome of 'normal' birthing.

The emergence of childbirth education classes and popular literature that deliver the message of a "good birth" has contributed to the mother's concept of birth. This "good birth" has come to be seen as an unassisted, uncomplicated vaginal delivery in which the woman is actively involved in the decision making process throughout the birthing experience. The mothers are surrounded by caring supportive others in a quiet, soothing, non-technical environment with little or no medical intervention.

This good view of birth for the majority of women is to be promoted and encouraged but the reality of unplanned surgical intervention for a small but significant group of women will always remain. It is important that all mothers be made aware of the possibility for intervention and what this may involve should it be necessary. Lack of awareness of the possibility of a surgical delivery appeared to be missing from current preparation for child birth classes attended by mothers in this study.

Additional factors include loss of control, loss of awareness of time and space, anxiety, dissatisfaction with the inability to cope during labour and unmet needs in relation to the midwife and medical staff during the delivery (Beck, 1992). Much of this is attributed to lack of knowledge and preparation for the possibility of a difficult birth during the ante-natal and the intra - partum stages and the lack of supportive care by health professionals following the birth. Jenson and Bobak (1985) found that whether a caesarean section was planned or unplanned, the loss of the experience of the delivery of a child in the traditional manner may have a negative effect on woman's self concept.

Oakley (1983), Kidd (1990) and Donevan (1977) all make reference to women's perceptions of not understanding reasons or of having control in the decision making during this time. This was also true of mothers in this current study.

Societal Views

In this present study the predominant societal view of birth was further endorsed by the mothers' perceptions of friends and family after the birth. The mothers felt that most people still believed that they had simply had a baby. The commonplace view of birth is that it was just part of life - one is not sick but just having a baby and that is what women do. This is in keeping with the demedicalisation of child birth and the return to natural childbirth as previously mentioned. How the baby was born did not seem to matter to others. Few other people really appreciated that these mothers had also had major surgery.

With some of my friends their attitude towards a caesarean is "oh well what an easy way to have a baby" and that really floors me. Interview 2.

My neighbour had heart surgery and beforehand the staff told him he was better off than women who have caesarean sections because the surgery is as basic as that, but with him he had heart surgery and women had just had a baby. People aren't very considerate. Yeah and I think that society is wrong, I think that they expect new mums to you know sit down and enjoy it and be glamour things that enjoy motherhood because its another terrific experience. They have this expectation that they will lie there with their makeup on and the eyes done and the baby will just pop out and go straight to the breast. I don't know what is about birth that makes them think like that. Interview 3

I had expectations from society I guess, of what I should and shouldn't be doing and you know I am a Mum now and I have to do that and I have to keep the house tidy and I have to cook and I have to clean and I have to do nappies, and I think I basically set myself up for enormous failure but I was too sore and miserable and couldn't do it. Interview 2

They have no concept of what was involved, the recovery time, nothing. My husband asked them not to visit and yet they still came the next day, that was really awful, a room full of visitors. I tried to cope with them to really focus but I was getting really exhausted, upset and tearful. I just wanted to be left alone, it was dreadful. Interview 8

Mothers felt that partners and close family still didn't really understand what it was like, even if they had been present at the delivery. This made them feel isolated and alone.

My family just didn't understand what I had been through. She was born in the morning and that evening they came to visit and really were cross and put out that I had not phoned them after she was born. I told them I couldn't get out of bed and how painful and awful I felt, but they just didn't hear me. They just didn't comprehend what it was like. I tell families now if I know someone has had a caesarean that you know she has had major surgery, she has a wound and she needs lots and lots of support and help for several weeks. Interview 9.

Childbirth practices have changed over time and will continue to do so. The perception of a normal birth will therefore also continue to change. Midwives need to be cautious in the messages that they give about birthing. Professional opinion is not isolated from the society in which it practises, as the professional view becomes accepted and reflected by the society at large. If midwives and other health professionals fail to recognise that women who have had caesarean births have also had major abdominal surgery and need specialised care, it is unlikely that others will, as is demonstrated in this study. If they fail to recognise that women need to make sense of this unexpected birthing experience and to provide supportive care, neither will others (Rapheal-Left, 1991).

Knowledge

Most mothers in this study talked about how little they knew about caesarean births. They commented that they believed very little had been discussed at the antenatal classes they had attended. Given that one in six women are likely to

have caesarean delivery, preparation classes appeared to be omitting to give information about an important aspect of birthing.

Some mothers recalled vague mention of the subject of caesarean delivery, while others recalled nothing about this method of delivery being discussed during their antenatal classes. Again the emphasis had been on normal birthing. Many felt very angry that they had had no preparation for the possibility of a caesarean birth.

....They just skimmed over it. Every book I have read since has either a paragraph and if you're lucky a page. Even the latest books that they give you in hospital now don't really. Interview 2.

I just had no concept at all. There was just no information on caesareans, I mean at our class we were told if you're lucky enough to have a caesarean you won't have anything to worry about ... And I had read all the birthing books I could get my hands on and there was nothing so we were sort of really unprepared. Interview 1.

Murphy-Black and Faulkner (1987) highlighted some of the mothers' criticisms of antenatal classes which included poor preparation sessions, conflicting advice, lack of realism about the birth and parenthood. In Hillan's study (1992) most mothers felt that caesarean sections were under played and little attention given to the need for an emergency section, or to postnatal problems that may occur, while nothing was said about how to cope with the pain and aftermath of a caesarean section.

One mother commented that her knowledge was based on what she had seen in hospital when she had her previous baby.

I had seen a lady one time when I had my other baby. She was really sick and that just put me off the idea of a caesarean so when the doctor told me I was going to have one I was a bit worried because of the memory. I never lost the memory of that lady, she seemed to suffer so badly. Interview 8

A number of negative responses to caesarean delivery among women delivered by this method have been reported (Affonso & Stichler, 1978; Cranley, Hedahl &

Pegg 1983; Marut & Mercer, 1979). These may reflect the disparity between the prior expectations of the birth and the actual experience, or may be a reaction to the presence of the complication or crisis which made the section necessary. During recent times the normalisation of childbirth and focusing of childbirth as a normal life event rather than a medical or illness related episode has raised expectations about childbirth. The evolution of things such as prepared childbirth, parent and extended family and close friend participation in labour, and an emphasis on gentle birth and early parent infant contact for bonding have all contributed to a revolution in attitudes of many parents (Rosen, 1989).

Health Professional Attitudes

The attitudes of health professionals met by women in this study were reported as causing much distress to mothers. Mothers often felt that they were going through an important major event but were seen to be just another caesarean section or just another woman who has had a baby. Sometimes the mothers commented that they thought they were a disappointment or a problem or just "a nothing" to the staff.

A lot of them were quite negative, you know, in the aspect of don't be ridiculous or you know you have two previous sections let's be realistic and book this one in. You know it sort of did get you down a little that approach. Interview 4

....at one point he [the doctor] said I have had women who have had a normal birth and a section and with the third they have come and asked for a section. I said are you telling me if a woman asks for a section she is given one. There are thousands of women out there who are giving birth vaginally out there every day whether they like it or not and he totally dismissed me. Interview 1

She [the midwife] seemed to just come along and you felt like you were just another caesarean, yet for me it was a major trauma. Interview 5.

I think the doctors have that problem in a big way, they now don't look at caesarean as a major abdominal operation, it's you just.. You are just having a baby like everyone else ... but you are not. Interview 2.

There is no consideration for the fact that you have had surgery. What planet are these midwives on and the people running the hospitals? I just can't believe that they never checked the wound, they never looked at my baby, nothing. There were three other women there who had actually been in longer than me and they had normal deliveries and they were all allowed to stay longer. No one asked where you were at, or how are you. Interview 3

Several mothers recalled a difference in attitudes between hospitals of different level. Level one hospitals are more like a birthing unit with no facilities for births other than low risk normal vaginal delivery. They have no medical support services on site. Level two hospitals are able to perform some abnormal deliveries and have limited medical, surgical and paediatric services. Level three units have full medical, surgical and paediatric services with intensive care facilities and personnel and are generally a regional centre. Level 1 and 2 units will accept post section mothers for postnatal care 48 hours after delivery. The level one unit staff had some difficulty accepting women who had required surgical interventions. Mothers felt that if you had not laboured and birthed naturally in "their" unit you were regarded as second best.

I don't think [name of the unit] are all that sympathetic to woman who had caesareans. Unless you have laboured and had your baby there they are really not too fussed, you know I was really disappointed in the whole attitude. They are anti-caesarean. Any care and attention that I had went out the door as soon as I got to [name of the level unit] I don't know if they don't like caesarean births, it is just so pro natural birth there ... that's how they view you there, as a big let down. Interview 3.

I think they get so out of touch with how hard it is. At the ante natal class they actually said if you have your baby here you can expect to get gold star treatment. If you choose go to this hospital or that hospital don't expect to get it. You can see where they are coming from, they have to encourage mothers to have their babies there. I mean it upsets

me because I was going to have my baby there, that's where I was always going to have my babies, it was not my fault I had to have three caesareans. I mean I tried to have each baby there. It's not my fault there wasn't any doctor brave enough to come out there and let me trial there. I was wanting to do that as well and I would have gone there too if they had let me, so they are taking away the choices and when you go there and they are so negative. It is as if we choose to have to have them [caesarean sections] and we are wrong for choosing that. Well I never chose to have a caesarean. I would have done anything to have a natural delivery. Interview 1.

The attitudes of staff were also described as unhelpful during the hospital stay, especially in regard to breast feeding. Many commented on the attitudes of the staff to breast feeding as being less than helpful and as upsetting them.

The midwife said to me breast feeding is nothing it is cracked up to be so don't worry about trying to do it. But I was worried about trying to do it, I really wanted to, I needed to. Some of the midwives were coming in and saying, oh look I had four babies I bottle fed and there is nothing wrong with it. Interview 5

For a reason that is not clear, breast feeding is a very emotive issue. In "The Politics of Breast Feeding," Palmer (1993) comments on the attitudes of staff as having a major effect on the breast feeding experience.

Facts about breast milk and breast feeding can be painful and even enraging to some women who have not breast fed their children, but the continual denial of the superiority of breast feeding and breast milk, supposedly to spare women's feelings is patronising, deceptive and unethical. (p. 83)

Many midwives allow their own experiences or those of others close to them to bias their views about breast feeding and indeed about childbirth itself. In doing so they cause much anguish to others. Of interest also was the perceived transference of the nurse's personal situation to the client. Several mothers felt that they didn't want or need to know about the conflicts and stress of the nurse as this increased their own state of distress.

One thing that the night nurse kept telling me was how tired she was and OK that's fine love, but I have just had surgery. I did not want to know, I've got a baby, I am vomiting I am in pain. She kept on telling me how tired she was and how busy she was but I actually wanted a little bit of attention here. I was really good last night and I will be a good girl tomorrow night but tonight I am vomiting and I need to handle my baby, but I can't handle my baby while I am being sick and the milk is coming in and emotions are starting to go ... I felt like I had to clean up the room myself. Interview 2.

It actually was a luxury to have some one listen to me and not give me their personal history and problems. Interview 5.

Klaus and Kennel (1972) highlight the fact that some influences which affect the relationship between the mother and her infant are fixed, while others such as attitudes of the staff are alterable and may be changed to improve the establishment of maternal relationship. In her research on postnatal care Ball (1987) found that the delivery of midwifery care had an effect on the transition to motherhood and could make a marked difference to the way that women adapted to the demands of mothering. Factors found to affect women were conflicting advice, rest, lack of continuity of care, communication between professionals and the women and communication between professionals. Although difficulties with communication can happen in any area they are more acute in the maternity service than any other (MacIntyre, 1982). They may occur in the course of ante natal care (MacIntyre, 1982), delivery (Reid & McIlwaine, 1980; Kirke, 1980; Kirkham, 1981) or the postnatal period (Ball, 1987). Comparatively few studies have attempted to evaluate the physical, psychological and social impact for women who have abdominal surgery at the same time as child birth. Much of this research is fragmentary and preliminary at best (Hillan, 1992).

Environment

During birthing, the woman's senses are bombarded not only by her own feelings and fears but also by events occurring in the birth environment. Environmental factors are of importance. When the decision to proceed with a caesarean section was made, mothers perceived that the environment became different. They remembered the rooms they were moved to in the operating theatre were more spartan and technological, with bright lights and lots of people and noise. The other birthing room had been quiet, with music, no technology evident and people talked in hushed voices and all seemed calm. People who had been clearly visible to them now became invisible behind green clinical clothing and masks and hats and screens. Several mothers felt they were very visible but the staff were not, and this changed the atmosphere and relationship with their care givers. They felt exposed physically and mentally.

....So I remembered looking at him and of course all I could see was his eyes because he had a mask on and a hat that seem very unfriendly.

Interview 5.

I had been vomiting for so long, green vomit, it was awful. Everything was green - the staff, the room, the bedclothes, drapes. They were hidden in the green but I was so obvious in the white gown I felt like a great big stranded whale that stood out like great beacon for all to see, but no-one could see them. Interview 9.

Affonso and Stichler (1978) comment that moderate to high anxiety sharpens one's perception of detail within the surrounding environment, but if anxiety levels increase to a high degree these minutely perceived details become distorted with the loss of the ability to correctly discern the details. Even if this is so the distress caused is very real for these mothers and is not being acknowledged.

I remember that being a big change, because I had wanted it to be natural and nice and pleasant and quiet and here I was with all these lights and people and noise. Interview 3.

The room was so cold and unfriendly it felt like a place of death not birth, no joy there at all. It was just like a factory really. Interview 6

Certain delivery units have areas that were perceived by the mothers to be ones you went to have a "natural delivery." Remaining within such an area was a key factor in thinking they were going to birth normally. Once moved from that room they felt they would no longer be able to birth normally and their coping abilities were reduced.

....I got hooked up to the machine there, so by this stage I was sort of starting to feel things were not going quite how I had planned it, but I was still in the blue room so I was quite confident ... I do remember going from the blue room which at the time was quite an important thing. Interview 5.

During the postnatal stage the surroundings were again very important for some women. Being in a single room was important to all mothers. When this had not occurred much misery resulted.

I wanted to be on my own. That was for no reason really, but seemed important at the time. On the fourth day they just ... when I was starting to feel like it was all coming together the midwife said we have to move you ... and that was it. I burst into tears and all sorts of things, I felt I was just getting going. It was just coming right and I had to go off, it wasn't so much that I was actually going to share a room, it was just that it was my little area. It felt like nobody was looking at where I was at and what my needs were. For me at the time I needed to stay where I was, that wasn't for any special reason but just because that is where I was at the time. Interview 5

The postnatal environment was noisy, with lots of people coming in and out of the room. The mothers were emotionally and physically exhausted and wanted quietness in which to rest and recover from the surgery. Lack of quietness increased the distress they were feeling and their experience of being overwhelmed.

It felt like an open ward, babies crying, women wandering up and down the place, the doors were open, husbands were in and out all over the show. It was chaos. Interview 2

Control

The degree to which women perceived themselves to be in control of their birth experience influenced their perceptions of birthing. Lack of control was taken to mean the inability to be in charge or to manage the experience. There has been much written in midwifery and social science literature about the sense of failure and disappointment which women suffer in not experiencing a vaginal birth. Often implied are feelings of loss of control over the birthing process and lack of understanding of reasons for interventions (Raphael-Leff, 1991; Wainer, Cohen & Estner, 1983). Being in control means being able to make informed decisions about one's own body and what happens during the birthing experience.

The need for informed consent, especially in New Zealand following the investigation into the treatment of cervical cancer at National Women's in 1987 was highlighted in The Cartwright Inquiry. This inquiry highlighted the need to ensure that informed consent is gained. Informed consent, according to the Cartwright inquiry and now widely accepted as the definition, requires

that the person has received sufficient information about the benefits and risks of the treatment to enable an informed decision to be made (Burgess, 1993, p. 34).

Ernest (in Burgess, 1993) puts it more simply;

informed consent means .. "Yes, I understand the diagnosis and the recommended procedure or treatment; the benefits, risks and complications involved; the alternatives to the procedures or treatments; and yes I give permission to touch, examine, treat attend or care for me"

A statistical analysis of the groups of women in New Zealand who have had caesarean sections indicates a high proportion were Maori and Polynesian, suggesting that language may be a barrier to understanding the reasons for surgery if English was a second language (Linton, Borman & Findlay, 1988). In her Glasgow study on morbidity related to caesarean section, Hillan(1992) found

that only 73% of women were able to correctly state the reason for caesarean delivery and 14% were completely wrong. Apart from her study there appears to be little direct research into women's understandings of the reasons for caesarean section.

Few mothers in the present study felt that they had made informed decisions before signing the required consent form.

They gave me the white stuff, wheeled me into the prep room and I asked the nurse if they were going to use forceps. I didn't know what a Caesar was. I didn't know how they were going to get her out or what they were doing. Interview 2

I am not really sure if they asked me, because I was on the mask I might have been out to it and they were talking to me but I can't recall too much about it. Interview 8.

I do remember somebody, I don't who, someone from one of the teams coming and saying it's up to you. It is your decision to have a caesarean and acutely feeling, well I don't have a choice because I mean I didn't want one and I was being told it was my choice. I didn't want to make that decision in a sense because I wanted to have this baby naturally and the messages that I was getting was that it wasn't going to happen that way. Interview 5

I would love to be able to say to the doctor you know, OK it's your job to explain things, that is what you have to do and to say to her and the nurses, you need to tell women that you are going to have a caesarean birth and its going to be hard work and its going to be painful but we can help you. Interview 10.

To feel in control is to be active in the experience and the decision making. Green & Coupland, (1990) found that lack of control was not necessarily related to the experience of intervention in a difficult labour. However the feeling of being in control became very important to the women not only when in labour but to their subsequent emotional wellbeing. Green et al stated that women who

do not feel in control, either of themselves or their environment, were least satisfied and least likely to feel fulfilled, and that they also had low postnatal well-being. This finding was independent of their antenatal expectations. One mother in this study who had a previous section recalled being in more control in the following pregnancy.

After the last experience I thought, actually consciously thought, I want to be more in control of this one. I would rather know if I did need a caesarean which I was hoping not to. I wanted to know who was doing what so I decided to have a specialist. Normally I would not want one. I had surgeons doing this major surgery on me - as far as I can remember I had not met them and they had done this major event on me, not just the surgery but delivering my baby and I had never met them before.

Interview 5.

Mothers felt they were not to able to make decisions and even when intervention was necessary they wanted to have some control over the way the interventions were to occur or who was going to care for them.

I was not advised of my rights as a patient. I was not told I could refuse to be there for students. Interview 1

....but then I got handed over to the specialist but meanwhile my independent midwife who was supposed to be with me through all this fell sick, and her partner who I had met, well she was tied up with another mother, so I had no control over who cared for me in the end.

Interview 7.

So the hospital midwives just took over from mine, that was sort of the end of my independent midwife's job whether I liked it or not.

Interview 6.

Another mother as an example of retaining control said

I had the control. I thoroughly checked with myself am I ready to have this baby this way. I checked in my head right in front of them, am I

ready to do this and this is my last pregnancy. I just did all that checking in myself and I was ready. Interview 2.

Mothers felt that the birthing experience had been taken over by others and that they had lost the ownership and control. It was no longer their baby or their experience or their decision. This caused them much distress and contributed to their feelings of miserableness.

They did exactly what they wanted, when they wanted. You know they told me what they were doing but when they wanted to, where they wanted to, how they wanted to. I was just an instrument for them to do what they wanted. I see Mums today and I stress to them, if there is any chance you are going to have a caesarean work out what you want, write it down what you want. If you aren't able to tell someone hand them a piece of paper, tell them to read it. That is all you have to do, and get out of it what you want, not what they want. Interview 3.

The ability to function with control is an important determinant for maintaining self esteem, and that when there is a loss of control, the risk of maternal role failure is increased (Nichols & Smith-Homenich, 1988). To be in control of such things as when to shower, when to feed the baby, when to have visitors, when to have pain relief and when to be discharged was seen as being important.

They came along and they said they would take the baby away and put her in the nursery. Well I didn't want that, I wanted her to be with me.
Interview 7.

For expectant mothers, birth is a major life event, marking the transition to parenthood which implies the achievement of social status and responsibility. But throughout this time the mother to be must also take on the subordinate and passive role of patient, which implies relinquishing responsibility in the face of professional expertise. Maternity care is something that is done to women. What has developed is that others control the birthing process and, as Rothman (cited Pratten, 1990) suggests, to manage or control a situation is to manage or control individuals. Pratten (1990) suggests that to medically manage birth is to

manage or control birthing women. Lack of power, control and autonomy during birthing lead to mothers' sense of miserableness.

Conclusion

In this chapter external and internal factors that caused the construct *miserableness* have been examined. It is clear that mothers who have unplanned major abdominal surgery at the time of birth are in a crisis situation. Their physical, emotional and intellectual distress is often ignored by professional health carers. When these needs are not met the mother's miserableness is increased. As a result she has difficulty in expressing her feeling about the birth experience. Her perception about her birth experience is often negative, yet society views birth as positive and happy occasion. The misfit between her expectations and reality leave the woman feeling angry and guilty and feeling she has failed, and she is often reluctant to ask for help. These feelings are often left unresolved. In this study midwives, nurses and doctors were seen to be influential in contributing to this miserableness.

The following chapter will discuss the conceptual model *Lost in the Normality of Birth*, which emerges from the data presented in chapters 4, 5 and 6. (Refer to Fig 2, p. 24).

Chapter Seven: Lost in the Normality of Birth

From this study emerged the overwhelming feeling that many things had been lost for these mothers. These losses were hidden and often neither well articulated nor clearly defined by the mothers or recognised by the midwives caring for them. In this chapter the conceptual model, *Lost in the Normality of birth* will be discussed.

Unidentified Needs

As shown in the previous chapters, mothers felt that they had had many needs but that they were unable to articulate them. The feeling of needing to be physically cared for, to have their pain recognised and managed in an appropriate way and to have their emotional and intellectual distress recognised were all spoken about. The women's need to experience birth in a variety of ways that was important to them was often not recognised or achieved. Many mothers felt unable to articulate their needs to the caregiver. Mothers recognised external expectations that they should have been feeling pleased about the most exciting and pleasurable event in their lives. These expectations arose from caregivers, family and society and when mothers expressed different emotions they were dismissed, ignored or trivialised. They felt that society only sees birth as having a child and not as also a maternal experience. This feeling may result from some women's view of birth as a meaningful event involving elements of choice and control, and lessening medical and technological intervention in which their needs are of equal importance to that of their baby's.

The need to be nurtured, to be cared for, comforted and supported was also very real and found to be lacking. Mothers said not that the carers were consciously uncaring, but rather that their needs related to having had surgery as well as having given birth were not always considered.

To be able to care for their own baby was an overwhelming instinct. However because of the physical restrictions from the surgery they felt unable to do this without assistance. This resulted in a loss of independence. Midwives failed to acknowledge that mothers needed extra assistance and support to carry out basic

tasks such as bathing, changing and feeding their babies - all of which mothers who had vaginal deliveries were more easily able to do independently.

The need to experience birthing in the manner they had been led to expect through reading, preparation classes and societal expectations was overwhelming. - there was a great desire to birth "normally", although what this actually meant appeared unclear. There were no clear definitions of "normal", but rather vague notions of what it should or might be like.

The basic social psychological process that emerges from this study is one of loss and grief. When birthing did not meet their expectations mothers often felt a sense of failure. Mothers then needed to make sense of the sequence of events that led to the deviation and to find meaning in the birthing experience in order that they could move forward to the role of mothering. Instead of a feeling of achievement what emerged was a disabling feeling of failure, grief and loss.

Loss is the state of being deprived of, or being without, something one has had. One can also lose an aspect of "self". Grief is an emotional reaction to loss. Studies have shown that the grief reaction is similar whether the loss is of a loved one or of a body part or function (Schoenberg et al, 1974). Grief work is the inner process of working through or managing the loss.

Mothers articulated many losses they had experienced during birthing. They felt they had lost the ability to birth normally, something they had come to regard as a normal womanly function. They felt they had lost control of the birthing experience and that it had then become other's" birth. The ability to carry out self-care for themselves and their babies had been lost or impaired. Mothers had become dependent on others for support. They were grieving for the loss of the birth experience they had anticipated and for the emotions they thought they should and would feel at the time of welcoming their new baby to the world.

Mothers in this study demonstrated the five stages of grief as described by (Schonenberg, 1974). These are:

Disbelief. In this stage mothers often said "No, it can't be that I need a caesarean section" and often there was no acknowledgment that the labour was not progressing well. After the birth some mothers did not acknowledge the emotions they felt about the need to have surgical intervention.

Questioning. All mothers questioned and looked for reasons for the "abnormal" birthing experience, asking what happened and how. For some mothers this occurred immediately after the birth, for others it was some time later.

Anger. Many mothers expressed anger at the care they received; at themselves for failing, at partners, family, health professionals and even at the very wanted baby.

Anger combined with desperation. Some mothers seemed resigned, dismayed and in despair about their experience.

Resolution. The final stage is the acceptance of loss. Most of the mothers in this study had not progressed through the grief process to this level. Most were still at the level of anger combined with desperation. This perhaps reflects the newness of the birth experience as all mothers had given birth in the last six months or perhaps that there had been no opportunity to deal with their emotions. Mothers who had previous caesarean experience also appeared to have been unable to resolve the previous losses experienced at these births.

Grief work can be helped or hindered by the mother's emotional status, by health professionals and by the ability of family or significant others to allow expression of grief. This expression of grief had not been allowed to occur for this group of mothers.

Lost in the normality of birthing.

What emerges from the construct *unidentified needs*, and the grief and loss that occurred as a consequence of unmet needs, is the over riding theme that mothers have become *lost within the normality of birthing*.

This group of mothers who give birth by unplanned abdominal surgery had not been recognised as having special needs in addition to the clearly defined and recorded needs of all birthing women.

Caesarean section mothers have become lost rather than hidden - to hide means that one can be found, revealed or uncovered, while to have lost something is to forfeit, wipe out, or miss. These mothers have lost the birthing experience they had hoped for, and the strong expectations and needs they felt at this time were

unmet. While these experiences can be identified through studies such as this, they can not be regained. For many mothers this may be their only birthing experience. Even if there are other births, no two birthing experiences are ever the same and neither are the expectations, hopes, fears and meanings for these mothers. These have been lost for ever. As one mother puts it so well;

I feel really sad that all I can say it was awful, terrible. It still makes me cry when I think about it. [five years later] What makes me even sadder is, what will I tell her when she asks about her birth, because all I can say was your birth was the worst thing that ever happened to me if one is to be honest. Not to be honest is to continue the myths about giving birth. How can one not be truthful about such a thing particularly as she one day will also want to give birth too. It really is so sad because you can't change it, re-do it, wind back the clock, no second chance. It is what it is. Interview 5

Chapter Eight: Discussion, Implications and Recommendations

Discussion

Within this research, women's experience of unplanned surgery at the time of childbirth has been explored. The grounded theory methodology as a research methodology has been used to analyse the data and has allowed the emergence of a conceptual model "*lost in the normality of birthing*". Arising from within the mothers' stories and the data analysis a number of implications for midwifery practice have emerged.

The individuality, diversity and commonalities within these mothers' experience have been identified. An important factor is that the experiences have occurred in several different care units, suggesting that the concerns raised by the mothers were not related to management policy or to care in one particular unit. There is also a temporal factor as some of these mothers had previous experiences with which to make comparisons - this has made it possible to identify changes in midwifery management of mothers having unplanned surgery at the time of birth. It is disappointing that in spite of the literature available and the evidence of previous studies the same concerns are still very evident. The mothers' voices are still largely unheard, their needs unrecognised and their voices are hidden within the 'normal birthing' environment. Mothers having unplanned caesarean sections have more negative than positive memories of their babies' birth and events that occurred at this time. This study has allowed for some of these voices to be heard and these women's needs identified.

Implications for the midwives

The central theme that has emerged in this study is that the needs of this group of birthing women are hidden and lost within the normality of birthing. The voices of these women have to date not been heard so their needs have been unseen and unmet. Mothers perceptions as described in Chapters 4, 5 and 6

illustrate well their unanswered emotional, physical and intellectual needs. Their views of the birthing experience and care they received are very negative. For many midwives and maternity services providers the first reaction is to perhaps disregard this negativity, wishing to believe that these were not recurring experiences but isolated incidences. However since the birthing experiences reported in this study occurred in a wide range of settings over a 6 month period it is not so easy to dismiss these accounts as uncommon. The reality is these are the stories of birthing mothers in 1995 and may well be the everyday experiences of mothers currently using the maternity services of New Zealand who have unplanned abdominal surgery at the time of birth. Within the stories and the other data collected there are many similarities to authenticate the birthing experiences, and therefore they are difficult to dismiss as isolated examples. This study is the first study to identify the needs of New Zealand women who have major abdominal surgery at the same time as birth within the current maternity services.

Marginalisation

It appears from this study that current maternity services are marginalising health care for this small but important group of women. Marginalisation is defined as;

the process through which persons are peripheralised on the basis of their identities, associations, experiences and environment. Marginalised persons are seldom directly consulted about their opinions and experiences. (Hall, Stevens & Meleis, 1994, p.25).

Under-resourcing of the maternity services in New Zealand is placing enormous pressures on beds and on staffing. The focus on 'normal' birthing is actively encouraging early discharge from units and minimising staffing levels. Because of their hidden-ness this particular group of mothers is also being subjected to the effects of these pressures. This group of birthing women are seen as merely occupying a postnatal bed and actively promoted for discharge as early as possible along with mothers who have had vaginal births. Staffing levels do not take account of the increased care that post-operative clients need and the load that this places on midwives, particularly during the first 48 hours. Without exception mothers commented on how busy the staff appeared. Such

workloads result in a less than desired standard of care being given, which frustrates both mother and midwife. Early discharge may be cost-effective for low risk women and so be encouraged, but for this group of mothers the opposite may be so, as giving inappropriate and inadequate care at this time delays recovery time and often results in the mothers requiring ongoing care which might otherwise have been avoided. The major concern from this study is that the present maternity services do not meet the needs of mothers who deliver by caesarean section.

The unmet needs identified by mothers in this study include the need to recover from surgery without the demands of caring for their baby 24 hours a day. These women need to have options about having the baby with them (rooming-in) or in the nursery for part or all of the early postnatal period to allow for rest and recovery from surgery. Mothers felt they needed more assistance with self-care needs, mothercraft and pain management. An overwhelming need for continuity of a caregiver through out the whole of the birthing particularly in the postnatal ward was identified (see chapters 4,5 & 6). When these needs were met mothers felt more positive about the birthing experience and the care they received. Their confidence in their ability to take care of their babies was enhanced and they felt more able to identify themselves as mothers.

Following the pressure from midwives to change the Nurses act in 1990 midwives became able to practice as autonomous practitioners. Midwives claimed to have the skills and knowledge to care for pregnant women throughout pregnancy. Where possible maternity service providers have also employed midwives rather than nurses to work in the service. Maternity care has become focussed on birth as a normal life event and policy, resourcing and practice reflect this. As this study demonstrates when women fall outside the bounds of "normal" their needs are often unmet as seen in this sample.

Midwives who work within the hospital setting may not have responsibility for total care but still remain responsible for their midwifery decisions and actions. If they are to claim the care of birthing women as theirs, they must demonstrate that they have the skills and knowledge to recognise and provide care that meets the needs of their clients.

Administrators and policy makers must also recognise that women who have unplanned abdominal surgery at the same time as birth will also have particular

service needs. From this study there appears to be an urgent need for consideration of an area within maternity units that is resourced for this small but significant group of mothers, so that they may receive care by midwives who have special skills in surgical nursing and midwifery. However in the current climate where the midwifery profession continues to hold the view that a midwife is a midwife and does not recognise areas of specialised practice, it seems unlikely that such specialisation will be possible.

Midwives bring advanced knowledge of the care of women and families in birth, while physicians and obstetricians bring skills in the abnormal. This study suggests that the result appears to be fragmentation and marginalisation of care with little co-ordination, continuity and overall responsibility. As a consequence the needs of mothers are not being met.

The more closely the birth experience comes to the mother's expectations, the less time and energy is needed for her to integrate the actual experience with the planned or fantasised birth, and the less need she has for dependent care. Midwives claim to be able to assist mothers best during the whole birthing experience, but mothers' experience of midwifery care in this study did not always support this. Hospital resourcing must also allow midwives to practise in a way that will allow them to meet the needs of their clients and to facilitate inter disciplinary communication. Low staffing levels and lack of inter-professional communication described by women in this study contributed to the mothers feelings of miserableness.

If they wish to claim the care of birthing women, midwives must also demonstrate they can provide care that meets the needs of *all* women who birth and not just those who meet the criteria of normal or low-risk, regardless of where they choose to have their babies and who is lead maternity care provider.

Implications for Midwifery Education

This study has shown several areas of concern for midwifery education, since midwifery practice does not occur in isolation from education. The majority of birthing mothers will require care that is focused on the 'normal' birthing process to guide them through their birthing experiences. However the educational preparation must also give midwives skills to care for the small but important group of mothers who will require major abdominal surgery at the

same time as birth. The question that midwifery education and the profession needs to address is; do all midwives need these skills if 'normal' birthing is the focus of practice? Students in midwifery programs may no longer have a nursing background and cannot always draw on past experience within the surgical area. It is also questionable how well people transfer skills from one context to another. If midwives are to care for babies and mothers who have surgery at the time of birth they will need a strong grounding both in low risk midwifery care and in specialised knowledge of post-operative care, including pain management. It could be argued that there is a need for a new breed of midwife skilled to care for women who do not fit the scope of 'normal' midwifery practice. A midwife with such preparation could then provide safe continuity of care for this currently marginalised group of women.

It is important that midwifery education recognises special needs during the birth and postnatal period and listens to the experiences of mothers about their perception of care, incorporating this knowledge into basic midwifery preparation. Midwifery education must prepare practitioners who are able to meet the needs of all birthing mothers who receive care within the current maternity services. Midwifery education must ask; are the experiences of the mothers in this study something that midwives can help resolve through better preparation programs?

Limitations of the study

While this study has explored the experiences and perceptions of mothers who have unplanned surgery at the same time as birth and developed these into a conceptual model there are limitations to this research that must be acknowledged.

The greatest limitation I found in carrying out this research was attempting to put into writing the voices of the mothers. The written word does not do justice to the intensity of feelings, disappointment and tears that these women so willingly and bravely shared in the hope for change in the care of future mothers. I trust that the reader is able to clearly hear the voices of these mothers and to appreciate the special needs that they feel are not being met by current midwifery care and maternity services.

A major limitation of this study is the time frame in which it was completed. As this was an academic work the requirements of the course submission dates needed to be met and this prevented more in-depth exploration of the mothers' experiences. Although there was evidence that saturation was beginning, further interviews would have confirmed this more clearly.

The study looked only at the experience from the mother's perspective. Future research is needed to explore the views of midwives regarding the care they think they provide and their perceived needs of mothers who deliver by caesarean section.

Had more time been available this study would have benefited from an exploration of other data sources, such the mothers' clinical notes and observations within the culture of the clinical practice area. There has been no attempt to understand clinical decision-making that may have influenced the outcomes for these mothers.

As this study only looked at mothers who had abdominal surgery there is no basis for comparison with mothers who had 'normal' birthing experiences within the New Zealand maternity services. Overseas literature suggested that some experiences are similar for both groups and therefore caution is warranted in assigning the outcomes solely to this group of mothers.

Recommendations for future research

There is considerable potential for research within midwifery using different methodologies that may improve the outcome for mothers and inform midwifery practice. Areas needing further study will be discussed briefly.

A study which examines New Zealand women's experience *planned* caesarean section or instrumental delivery would be of great value. In addition, a comparison of mothers' perceptions of uncomplicated births with those of mothers who have had unplanned surgery would assist in defining factors that can be identified as being particular to the second group.

To date little has been found within the literature which refers to midwives' views of the needs and care of mothers who have a caesarean birth. This would be a important area of enquiry that may help identify midwifery education needs and outcomes.

The need for continuity of care for women who have unplanned surgery at the time of birth within the current maternity care service has not been researched. All mothers commented in this study on the need for continuity of a primary care giver, and this appears to be area of importance to consumers.

Research into pain management for mothers in the postnatal period is also needed, as understanding and management of pain for this group appears not to be adequate. Comparison of pain management for other surgical procedures may demonstrate other regimes that could be utilised and tested within the obstetric area.

Conclusion

Grounded theory methodology has been used to explore the experiences of mothers who had unplanned abdominal surgery at the same time as child birth. A conceptual model that captured the impact on the mothers of this experience was developed. It was found that many events occurring during and post delivery contributed to reactions that were generally more negative than positive. These experiences have had a lasting effect on these mothers and those close to them and have affected their experience and memories of birth and their adjustment to parenting.

Midwives have an important role to play and are in a privileged position to uncover the unidentified needs of birthing mothers who also require major abdominal surgery at the same time as birth, and to reflect on the meaning this may have for midwifery practice and the maternity services in which they work. For many participants in this study this was the first opportunity they had had to be listened to, to be believed and to normalise their experience. In expressing themselves they found meaning in their birthing experience. The voices of women need to be heard, and midwives must listen, if midwifery care is to be truly women-centred and a partnership developed with birthing women that meets their physical, emotional, intellectual, and spiritual needs. Only then can birth become a rewarding experience.

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Appendices



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Appendix One

Women's experience of major abdominal surgery at the time of childbirth

Information for research participants

The purpose of this study is to gain a better understanding into the experiences of women who have unplanned surgery (Caesarean section) at the time of childbirth. Participants in this study will be asked in taped interview to tell about their experiences. It is hoped that this information will be used to improve nursing and midwifery care and increase maternity services personnel's understanding of women's need at this time.

The researcher will be Heather Jackson, an experienced nurse and midwife who is currently studying for a Master of Arts degree at Massey University. Her supervisor will be Valerie Fleming, lecturer, Department of Nursing and Midwifery, Massey University. Heather may be contacted by phone on (09) 846 1992 or Valerie at (09) 443 9700 ext 4323.

If you agree to participate in this study you will have the right to ask further questions or stop the tape recording at any time. In addition you will be free to withdraw your consent at any time. The information you provide is completely confidential to the researcher and her supervisor. Any typist used during this research will have signed a non disclosure agreement. It will not be possible to identify you in any reports that are prepared from this study.

You will be given a copy of the summary of the study's findings and your tapes returned to you on completion of the study.



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Appendix two

Women's experience of major abdominal surgery at the time of childbirth

Consent form

I have read the information sheet for this study and I have had the details of the study explained to my satisfaction. My questions about the study have been explained to my satisfaction and I understand that I may ask further questions at any time.

I understand that I am free to withdraw from the study at any time or to decline to answer any particular question. I agree to provide information to the researchers on the understanding that it is completely confidential and tapes will be returned to me on completion of the study.

I understand that the data may be used for the purposes of writing a thesis and for any papers that may result from this thesis in which I shall not be identifiable.

Signed.....

Name.....

Date.....

Researcher.....

Date.....