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First Time Mothers' Experiences of a Planned Cesarean Birth

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First Time Mothers' Experiences of a Planned Cesarean Birth

Denise M. Puia, PhD

University of Connecticut, 2015

The elevated cesarean birth rate continues to be an issue of concern. Many of these births are to first time mothers. Numerous studies have been conducted to examine specific physiological or psychological complications of a cesarean birth. Yet little research has been done to qualitatively explore the overall experience of women having a cesarean birth and none have focused exclusively on first time mothers' experience of a planned cesarean birth.

The purpose of this narrative analysis of first time mothers' planned cesarean birth stories was to gain insight into the entire physical and emotional response to the cesarean birth experience, beginning with the preceding factors that influenced the women to have a planned cesarean birth, including the birth itself, and concluding with the recovery and postpartum period. Narrative analysis is a type of qualitative design in which the participants' story is the object of inquiry. A convenience sample of 11 first time mothers who underwent a planned cesarean birth was interviewed either by email or face to face. The data were analyzed using Reissman's method of thematic narrative analysis. Each narrative was analyzed as a whole and the results were discussed within the theoretical framework of Roy's Adaptation Model to produce thematic categories. Similarities were identified and used to create a metastory which revealed seven overarching themes: Decision, not much of a choice; Acceptance of birth method; Emotional roller coaster of birth, Physical recovery, feeling like myself, Emotional recovery, a kaleidoscope of feelings, Expectations, a picture in my mind; Outcomes, ties that bind.

This study reveals valuable clinical implications. Healthcare providers need to work to improve policies to decrease maternal-infant separation during the cesarean birth. Education

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needs to be provided to the woman and her support person to decrease fears and help create realistic expectations. This study will guide providers to make improvements in providing holistic maternity care specific to first time mothers having a planned cesarean birth.

Recommendations are made for clinical practice, education, and research. Increased education and support can lead to a positive experience despite having an alternative birth method.

First Time Mothers' Experiences of a Planned Cesarean Birth

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A Dissertation

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Denise M. Puia

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APPROVAL PAGE

Doctor of Philosophy Dissertation

First Time Mothers' Experiences of a Planned Cesarean Birth

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DEDICATION

I dedicate this dissertation to my husband, Dino, my daughters Alyssa, Kayla, and Dina, and my son, Joseph. Without your love and support I never would have been able to accomplish such a monumental task. You mean the world to me and I am grateful to have such a loving family!

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Chapter One: Introduction

Chapter one introduces the research study, First Time Mothers' Experiences of a Planned Cesarean Birth. The history and significant statistics related to cesarean birth are presented in the background section. The significance of this study is discussed in relation to the potential physical and emotional consequences of a cesarean birth, the special considerations of a planned cesarean, and the specific impact on first time mothers. The chapter ends with the purpose of the study and an introduction to the dissertation chapters.

Background

Cesarean births have been a method of delivery since ancient times and were present in both Western and non-Western civilizations (Sewell, 1993). It is believed that the term cesarean section originated when under the Roman Emperor Julius Caesar a law was decreed that all women who were about to die during childbirth be cut open in order to save the life of the child. Caesar felt it was more important to save the life of the child thus increasing the Roman population (Sewell, 1993). It wasn't until the 19th century and the development of cities, hospitals, anesthesia, and antibiotics that cesarean birth became a commonly accepted safe alternative to vaginal births (Sewell, 1993).

In the United States, when the cesarean birth rate began to be measured in 1965 it was at 4.5% (Taffel, Placek, & Liss, 1987). According to the World Health Organization this fell within the acceptable range of below 15% (World Health Organization, 1985). Over the next two decades the rate continued to rise on average of 1% a year resulting in a cesarean birth rate of 22.7% by the year 1985 (Taffel et al., 1987). The cesarean birth rate remained relatively constant over the next 5 years and even saw a slight decline in the early 1990's to 21% (Menacker & Hamilton, 2010). This slight decrease may be in part related to the increased

number of women attempting a vaginal birth after cesarean (VBAC) from 5% in 1985 to 28.3% in 1996 (American College of Obstetricians and Gynecologists [ACOG], 2010). With the increased number of VBACs the rate of uterine rupture and complications increased causing providers to counsel against VBACs and instead schedule a repeat cesarean birth. ACOG (2010) has since revised their position and has stated that VBAC is safe for most women who have had only one prior cesarean birth. However, it is not yet clear how these new guidelines will impact the cesarean birth rate over the long term.

Since 1996, cesarean birth rates have been increasing at a startling rate of almost 60% (Martin et al., 2012). There have been several theories as to the reason for the increased rate including; maternal request, increased liability pressure, and change in culture. In a study conducted by Weaver, Statham, and Richards (2007), 77% of the obstetricians felt maternal request was a main contributor in the rising cesarean birth rate. Yet in several reviews of the literature the results of maternal request were unclear ranging from 0.3 to 14 percent (McCourt et al., 2007; Robson, Tan, Adeyemi, & Dear, 2009; Thompson, 2010). Similar results were found in a recent national survey when only 1% of participants reported a cesarean for maternal request (Declerq, Sakala, Corry, Applebaum, & Herrlich, 2013). Another popularly held belief is the fear of malpractice liability is a driving force in the elevated cesarean birth rate. However, current research does not support this theory (Sakala, Yang, & Corry, 2013).

Another theory for the increase in cesarean births is cultural knowledge and the misrepresentation of birth in the media has led to the increased number of cesarean births (Morris & McInerney, 2010; Munro, Kornelsen, & Hutton, 2009). Analysis of reality-based television shows revealed a portrayal of vaginal birth as having many complications and as dangerous to mother and baby. In contrast a surgical birth was depicted as safe and easy (Morris

& McInerney, 2010). In addition to television shows many women rely on other women's birth stories for information about childbirth. Similar to television shows, women's childbirth narratives often focus on the negative aspects of vaginal birth and the positive experiences of a cesarean birth (Munro et al., 2009). While the presence of inaccurate depictions of birth has been shown it is unclear the exact effect these stories have had on the cesarean birth rate.

Presently, the cesarean birth rate has been stable since 2010 at 32.8% (Martin, Hamilton, Osterman, Curtin, & Mathews, 2013) such that approximately one in every three American women will give birth by cesarean. In fact, according to Pfuntner, Wier, and Stocks (2013) cesarean birth was the most common major operating room procedure performed in 2010. Women having their first child comprise more than one third of these cesarean births (Zhang et al., 2010). These rates may vary according to geographical region. The cesarean birth rate may be as low as 22.6% in Utah to a high of 40.2% in Louisiana (Martin et al., 2013). Similar geographical differences can be found in other countries like Canada where the rates range from 34.4% in Nova Scotia to 44.6% in British Columbia (Kelly et al., 2013). Internationally, there is an even bigger discrepancy as cesarean birth rates range from 2.9% in Sub-Saharan Africa, to 26.3% in Southeast Asia, to 80-90% in private hospitals in Brazil (Callister, L.C., 2008). The rate of cesarean births is essentially the same for Non-Hispanic white women and Hispanic women at 32.3%. Non-Hispanic black women have the highest reported cesarean birth rate at 35.8% (Martin et al., 2013). The focus of this study was on primipara women who underwent a planned cesarean birth. It is important to understand both the factors that influence primipara women to have a planned cesarean birth and the physical and psychological outcomes since more than half of these women will go on to have repeat cesarean births with subsequent pregnancies (Guise et al., 2010).

Significance

A cesarean birth is a major operation with risks to both mother and neonate. Higher infant and maternal morbidity and mortality rates have been shown with cesarean births (Wax, Cartin, Pineete, & Blackstone, 2004). In fact, the elevated cesarean birth rate is believed to be a contributing factor to the significant increase in the maternal morbidity rate between 1998 and 2011 (Callaghan, Creanga, & Kulina, 2012). Numerous studies have been conducted to examine the physiological complications of a cesarean birth (Chong & Kwek, 2010; Macdorman, Menacker, & Declercq, 2008; Miesnik & Reale, 2007; Wahlman, 2009; Wax, Cartin, Pineete, & Blackstone, 2004). Immediate maternal complications include fever, infection, pneumonia, and thrombolytic events (Miesnik & Reale, 2007). The risk of admission to an intensive care unit is ten times more likely with a planned cesarean than with a vaginal birth (Chong & Kwek, 2010). Long-term complications include increased risk of placental abruption, placenta previa, and uterine rupture with subsequent pregnancies (Macdorman et al., 2008; Wax et al., 2004). Infants born via cesarean are at higher risk of respiratory problems (Macdorman et al., 2008). Another study found that infants born by a planned cesarean had two times the risk of being admitted to the neonatal intensive care unit than those infants born via a planned vaginal delivery (Kolas, Saugstad, Daltveit, Nilsen, & Oian, 2006). Cesarean births have also been shown to impact breastfeeding. Mothers who give birth by cesarean are less likely to have skin-to-skin within the first hour, less likely to have initiated breastfeeding within the first two hours, and are more likely to use formula while in the hospital than women who give birth vaginally (Augustin, Donovan, Lozano, Massucci, & Wohlgemuth, 2014). Infants born by cesarean are also less likely to be exclusively breastfed (Chalmers et al., 2010; Zanardo et al., 2010).

While many studies have examined the physical complications of cesarean birth, far fewer studies have been conducted to explore the psychological sequelae. Current research often measures particular emotions such as fear, control, depression, or pain (Bland, 2009; Gray, 2005; Lobel & DeLuca, 2007; Nerum, Halvorsen, Sorlie, & Oian, 2006; Tinti, Schmidt, & Businaro, 2011). Some women elect to have a cesarean birth because of fear of labor pains and/or fear of lack of control (Nerum et al., 2006). Other negative emotions such as anxiety and fear have been shown to increase feelings of pain (Tinti et al., 2011). Several studies have found women who gave birth by cesarean experienced lower levels of satisfaction and control than those women who delivered vaginally (Bland, 2009; Gray, 2005). Women who deliver by cesarean have also been shown to be at higher risk for postpartum mood disorders (Gray, 2005; Lobel & DeLuca, 2007).

The emotional aspects of women's experience of cesarean birth are particularly important as research has shown that women who have undergone an operative delivery are more likely to experience psychological trauma symptoms (Gamble & Creedy, 2005). Increased incidence of postpartum depression have been associated with cesarean births (Martini, Knappe, Beesdo-Baum, Lieb, & Wittchen, 2010; Weisman et al., 2010). Low levels of perceived control and satisfaction have been associated with increased incidence of postpartum depression and even posttraumatic stress disorder (PTSD) (Beck, Gable, Sakala, & Declercq, 2011; Lobel & DeLuca, 2007). Low levels of perceived control were reported in a recent study, where two-thirds of mothers who had had a primary cesarean birth indicated the doctor was the main decision maker (Declercq, Sakala, Corry, Applebaum, & Herrlich, 2013). Furthermore 13% of the mothers surveyed indicated they felt pressure from the physician to have a cesarean birth. In a similar

study on women's birth preferences only 16% of women preferred a cesarean birth (Mazzoni et al., 2010).

Childbirth is a monumental life altering experience that is multidimensional and encompasses more than just the outcome of a healthy infant. Each birth is unique and the expectations of each woman are varied. Nursing should not only provide safe, competent care, but also should be aware of a woman's response to her birth and work to enhance the emotional and psychological experience for the woman and her significant other. It is important to consider the woman's perception of her delivery rather than the just actual outcome because it is the woman's perception that determines whether the event is considered traumatic or gratifying (Beck, 2004). Olin and Faxelid (2003) also realized the importance of women's perception when there was a need for the parents to discuss the birth even if the delivery was without complications. Similarly, Stadlmayr, Schneider, Amsler, Burgin, and Bitzer (2004) found women who had elective cesareans experienced higher levels of negative emotions immediately postpartum than women who delivered vaginally. Like results were found in another study when women who had a planned cesarean birth were not pleased with the decision making process or the antenatal care and reported a more negative birth experience than the women who had a planned vaginal delivery (Karlstrom, Nystedt, and Hildingsson, 2011). Just because the cesarean birth was a planned procedure it does not mean the event was without perceived difficulties, thus the significance of evaluating the experience from the woman's perspective.

In addition to the experience the number of prior deliveries she has had may further influence the woman's perspective. The birth of a child is a life altering experience and one a woman will remember for her entire life. The impact of the birthing experience may have a greater effect on first time mothers because they have no prior experience with which to compare

it (Dahlen, Barclay, & Homer, 2010). Evaluation of a first time mothers' experience is especially important because it can impact future childbirth decisions (Stadlmayr et al., 2006). In a study of 235 women 23.8% of women who preferred a vaginal delivery late in pregnancy changed their preference to elective cesarean birth for future deliveries (Pang, Leung, Lau, & Chung, 2008). Furthermore, women who had a planned cesarean birth for their first child were more likely to have a repeat cesarean birth (Pang et al., 2008).

Another factor that may impact women's perspectives of their births is the nurse patient relationship. The intrapartum nurse is the primary caregiver during a woman's birthing experience, whether it is a vaginal delivery or a cesarean birth and therefore, has a pivotal role in shaping the birthing experience. The woman's perceived relationship with her caregivers has been shown to impact her postpartum adjustment (Stadlmayr et al., 2006). In a negative childbirth experience a positive relationship with healthcare providers can improve adjustment, and in a positive childbirth experience a negative relationship with healthcare providers can worsen the adjustment (Stadlmayr et al., 2006). In another study (Bryanton, Gagnon, Johnston, & Hatem, 2008), the importance of the nursing support was found to be one of the most important predictors of a positive experience in planned cesarean births.

The current body of research has explored specific aspects, either physical or psychological, of a cesarean birth yet little research has been done to explore the overall experience of women having a planned cesarean birth. Only a few studies have qualitatively explored the overall experience of a cesarean birth (Bluml et al., 2012; Fenwick, Staff, Gamble, Creedy, & Bayes, 2010; Fries, 2010; Puia, 2013; Redshaw & Hockley, 2010). Bluml et al. (2012) interviewed 48 women before and after a planned cesarean birth and found only 54% of the women felt sufficiently informed about the procedure. After the birth 83.3% of women reported

feelings of anxiety related to the health of their baby, anesthesia, the surgery itself, and postoperative pain (Bluml et al., 2012). In another study 59 women who were having either a cesarean or a vaginal birth after cesarean were surveyed about their birth experiences (Fenwick, Gamble, & Mawson, 2003). The results indicated cesarean birth was physically and emotionally traumatic for 78% of the women. A meta-synthesis was conducted of 10 qualitative studies about women's experiences of cesarean birth (Puia, 2013). The resulting themes conveyed emotions of fear, failure, dependency, and disappointment. Fries (2010) examined the overall experience of African American women, but these women had an unplanned cesarean birth. Analysis of the data revealed themes of mistrust, sacrifice, and feeling rushed. Redshaw and Hockley (2010) analyzed open-ended questionnaires from 2960 women who underwent a cesarean birth. No qualitative studies of first time mothers' overall experiences of planned cesarean have been conducted. The gap in the literature demonstrates the need for more research to provide an understanding of contemporary first time mothers' experiences of planned cesarean birth, including both the physical and emotional aspects, in a culture where cesarean birth has become commonplace.

Purpose

With the elevated rate of cesarean births comes the need for healthcare providers' awareness of the unique needs of first time mothers' undergoing a planned cesarean birth. The purpose of this narrative analysis was to develop a metastory of first time mothers' experience of a planned cesarean birth. The experience included the entire birthing process; beginning with the preceding factors that influenced primipara women to have a planned cesarean birth, including the physical and emotional experience of the birth itself, and concluding with the postpartum period and complete recovery. The postpartum period is typically defined as the 6-8 week period

beginning with the birth of the infant and concluding with the involution of the uterus and the return of all reproductive organs to their prepregnant state (Perry, Hockenberry, Lowdermilk, & Wilson, 2010). Yet other research has shown that psychosocial and emotional changes may continue to take place up to a year after the birth (Declercq et al., 2013; Fahey & Shenassa, 2013; Mercer, 2004). For this reason the women were asked to conclude their story when they felt they had completely recovered.

Riessman's (2008) thematic analysis approach to narrative analysis focuses on the story as the object of investigation. Such an analysis allows the investigator to determine how the respondents made sense of an event in their lives. Additionally, narrative analysis is also helpful "... for what they reveal about social life- culture "speaks itself" through an individual's story" (Riessman, 1993, p. 5). This study explored the entire experience of first time mothers' planned cesarean births in a culture where cesarean births are normative. The goal was to attain a more comprehensive perspective of their birth stories. This detailed perspective will help to guide improvements in providing holistic maternity care specific to primipara women having a planned cesarean birth such as securing increased social support, acquiring information to develop realistic expectations, and identifying additional self-care needs.

Conclusion

Despite the prevalence of cesarean birth, few studies have been conducted to explore the women's overall experience (Bluml et al., 2012; Fenwick, Gamble, & Mawson, 2003; Fries, 2010; Puia, 2013b). Bluml et al. (2012) interviewed both primiparas and multiparas women. Fenwick, Gamble, and Mawson, (2003) examined women having a cesarean birth and those having a VBAC. Another study described the experience of African American women who had an unplanned cesarean birth (Fries, 2010). A meta-synthesis of women's experiences of cesarean

birth included studies of multiparas, primiparas, emergent and planned cesarean births (Puia, 2013). Redshaw and Hockley, (2010) studied women who had either a planned or unplanned cesarean birth. No studies have specifically explored the experience of primipara women having planned cesarean births. This study begins to fill the gap in the literature by exploring primipara women's stories of their planned cesarean births.

Chapter one introduces the research study, First Time Mothers' Experiences of a Planned Cesarean Birth. The history and significant statistics related to cesarean birth were presented in the background section. The significance of this study was discussed in relation to the potential physical and emotional consequences of a cesarean birth, the special consideration of a planned cesarean, and the specific impact on first time mothers. Lastly, the purpose of the study was presented. A review of the literature is presented in Chapter two. Chapter three explains the method, narrative analysis, using the structural approach of Reissman's (2008) thematic analysis. In Chapter four the results are discussed. A detailed description of the participants is given. The narratives are summarized and individual themes from each interview are discussed. The metastory of first time mothers' experiences of a planned cesarean birth is offered. The significance of the study is explained in Chapter five. The results of this study are compared to the review of the literature and suggestions for future research, clinical practice, and education are discussed.

Chapter Two: Review of Literature

Introduction

Chapter two presents the literature related to first time mothers' experiences of a planned cesarean birth as well as various aspects of a cesarean birth and the overall experience. The research studies are categorized into the following categories: decision making, satisfaction, and experience. Each category is described and details of the studies are discussed.

Procedure

No studies that focused on first time mothers' experience of planned cesarean birth were able to be located. Thus the review of literature was expanded to include women's experiences of cesarean births. Still relatively few studies were able to be located so the scope was further broadened to include studies that evaluated various aspects of a planned cesarean birth. Online databases such as Cumulative Index to Nursing and Allied Health Literature (CINAHL), PubMed, and PsycInfo, were searched. Key words such as: *cesarean, cesarean birth, cesarean section, planned cesarean, elective cesarean, decision-making, satisfaction, maternal satisfaction, patient satisfaction, experience, birth experience, childbirth experience, maternity experience* were used. The search criteria were limited to those studies published in English and from the year 2000 to the present in order to capture the childbirth experience of contemporary women in a culture where birth is medicalized and cesarean birth is normative.

Results

This search strategy produced 31 research studies for examination in this literature review. All of the studies except two were published within the past decade. The studies were from a variety of disciplines including 10 from Nursing, ten from Medicine, four from Midwifery, three interdisciplinary, two from Public Health and one each from Psychology and

Sociology. The studies were conducted from around the world; however there were only six from the United States. The majority (n=7) of the studies occurred in the United Kingdom. Four studies each came from Canada, Australia, and Sweden. Two studies were conducted in Austria. Germany, New Zealand, Norway, Scotland, and Switzerland each provided one study. The majority (n=17) of the research studies were quantitative. In addition there were 11 qualitative studies and three mixed methods studies. More information regarding demographic and methodological characteristics of the individual studies are displayed in Table 1. The following sections provide an in-depth discussion of the literature.

Decision-making

The overall experience of a planned cesarean birth begins with the decision making process and thus the first category of this literature review is decision making. This category consists of quantitative, qualitative, and mixed methods research studies. It is further subdivided into the categories of process and motivating factors.

Process. A planned cesarean birth begins with the decision making process. Two quantitative studies evaluated this process (Kolip & Buchter, 2009; Lagan, Sinclair, & Kernohan, 2010; Puia, 2013a). Kolip and Buchter (2009) examined first-time mothers who had a planned cesarean birth. A self-assessment questionnaire was given to 352 women to evaluate their involvement with the decision-making process, levels of satisfaction with the information provided, and satisfaction with the choice of delivery method. Over 75% of the women felt they had received adequate information from the physicians and midwives about the surgery, but only 58% of the women felt they had received enough information about the consequences. The majority of women (62.3%) were happy with their choice of birth method. In a similar study, 101 women who had given birth by cesarean were surveyed (Puia, 2013a). The sample consisted of

56 first time mothers and 45 women who had a repeat cesarean. Of the first time mothers 23 had scheduled cesareans and 32 had unplanned cesarean births. Doctor recommendation was the most frequently reported reason for a primary cesarean. Although, the majority of women (94.9%) relied on their physician as the main source of information, friends and relatives were also reported as frequently used resources. Most of the women (97%) remembered being provided with information on all aspects of the surgery. The women felt they had understood the information and that it was helpful. Overall, the women reported being satisfied with their decision for a cesarean birth (Puia, 2013a). Results of both studies indicated the women primarily received information from their physician and were satisfied with the information they had received and with their choice of birth method.

The third quantitative study revealed contrary findings indicating women were not satisfied with the information provided by their doctors and thus turned to the Internet for support (Lagan, Sinclair, & Kernohan, 2010). Six hundred thirteen women completed a survey about their use of the Internet for pregnancy related information. Results indicated 83% of the women had their decision influenced by the Internet. Almost half of the women were not satisfied with the information provided by their healthcare provider and 94% of the women used the Internet to supplement the information they were given by providers (Lagan et al., 2010).

The decision making process was further evaluated in two descriptive qualitative studies (Kornelsen et al., 2010; Munro et al., 2009). Kornelsen, Hutton, and Munro (2010) explored the decision making process by conducting in-depth interviews with 17 first time mothers who requested a cesarean birth. Results of the study revealed three themes: participants' decision making process, experiences of the cesarean, and the influences of birth stories on attitudes towards mode of delivery. Many of the women had decided to have a cesarean prior to even

becoming pregnant. For other women advanced maternal age, family history and fear of childbirth and harm to the infant were factors in the decision. For all the women the informed consent process served to reaffirm their decision making process. Many of the women felt their doctors provided thorough explanations and willingly answered questions. The women reported feeling supported by their physician in their choice of birth method. The women also described making their decisions within the context of a society with a high cesarean birth rate and an acceptance of the elective cesarean. In addition these women discussed how other women's birth stories were highly influential in their decision making process (Kornelsen et al., 2010).

Munro et al. (2009) found similar results in their study, which investigated the influence of birth stories and cultural knowledge on women's decisions to have a cesarean birth. Seventeen first-time mothers who had a patient-initiated elective cesarean were interviewed about their decision-making process. Women looked for sources of information to help with the decision making process and found birth stories to be very influential. Women reported hearing birth stories through prenatal classes. Other women sought out family and friends to acquire narratives and get what they perceived to be an accurate depiction of birth. Analysis of the birth stories revealed a focus on positive cesarean births and negative vaginal delivery stories. Similar messages were conveyed through cultural narratives including stories from television and the Internet. The cesarean stories highlighted shortened delivery times and controlled environments thus motivating the women to opt for an elective cesarean birth (Munro et al., 2009).

Three studies used a mixed methods approach to evaluate the decision making process (Kingdon et al., 2009; Weaver et al., 2007; Wittmann-Price, 2006). Weaver et al. (2007) conducted a mixed methods study to examine whether or not women in the United Kingdom were requesting cesarean births without clinical indications from the perspectives of both women

and obstetricians. The women were asked to complete a questionnaire about previous pregnancies and birth wishes for present pregnancy. In addition the women were asked to keep a diary of events that made them think of the type of birth they wanted to have. The obstetricians completed questionnaires about their views of cesarean births and participated in semi-structured interviews. One hundred ten women indicated they had taken part in the decision making process for a cesarean birth. The majority (69%) of the women wanted a vaginal birth. Of these women 60% had emergency cesarean births and were not interviewed. The remaining 44 women were interviewed. In this study all women who requested a cesarean believed they had a clinical indication, although they did not always feel their reasons were supported by the physicians. Results indicated that women's fear for the safety of their baby played a major role in the decision making process. Furthermore, in many cases the women viewed cesarean as a safer alternative to vaginal deliveries (Weaver et al., 2007).

Wittmann-Price, Fliszar, and Bhattacharya (2011) conducted a mixed-methods study of 50 women who had given birth either vaginally (n=35) or by cesarean (n=15) to determine if the women used emancipated decision making (EDM). EDM is a theory comprised of a flexible environment, personal knowledge, and awareness of social norms to evaluate the shared decision making between the patient and the provider. In this study the revised Emancipated Decision Making scale (EDM-r) (Wittmann-Price, 2006) the Satisfaction with the Decision scale (SWD) (Holmes-Rovner et al., 1996) and open-ended questions were given to eligible participants while on the postpartum unit and were returned over a period of three months. Of the 50 women who supplied qualitative data 74% felt they had a choice in their delivery method. All the women felt they had received adequate information. The results indicated while both groups were using EDM, the vaginal delivery group experienced a stronger process with their choice of delivery

method. However, there was no statistical difference in the levels of satisfaction with their decisions between the vaginal deliveries and the cesarean (Wittmann-Price et al., 2011).

Kingdon et al. (2009) conducted a mixed methods study to explore women's views of the decision making process for maternal request cesarean births in England. Data were collected from 443 first time mothers using a combination of questionnaires and interviews at multiple points before and after delivery. The questionnaires were distributed at the first prenatal appointment and again at 24 and 36 weeks gestation. The semi-structured interviews took place at 24 and/or 36 weeks gestation. The final interview was conducted at 12 months postpartum. Of the 397 women who completed the initial prenatal questionnaire, 72% reported they would prefer to give birth vaginally and only 3% reported they would prefer a planned cesarean. The results of the 24/36 week questionnaire indicated a decline of those women wanting a cesarean birth down to 2%. Of the women who indicated on the 24 or 36 week questionnaire that they wanted a planned cesarean, all of them had changed their minds at least once. These results indicate that the decision making process is ongoing and dynamic and a woman's choice may fluctuate throughout the pregnancy. Furthermore, many women felt the decision making process should be left to the physicians because while patient autonomy is important the women valued the knowledge of their physicians and their main concern was for the safety and wellbeing of their babies (Kingdon et al., 2009).

The majority of these studies revealed women's satisfaction with the information provided by their physicians. However, women also sought out additional information from the Internet and birth stories from family and friends. These additional sources of information were highly influential in women's decision-making process. Those women that requested a cesarean birth did so out of fear for the safety of their babies.

Motivating factors. While some studies focused on the overall process, others examined specific factors that influenced a woman's decision to have a cesarean birth. Several studies qualitatively explored the motivating factors of women who elected a cesarean birth were found (Arthur & Payne, 2005; Fenwick, Staff, Gamble, Creedy, & Bayes, 2010; Weaver & Statham, 2005). Arthur and Payne (2005) conducted an interpretive phenomenological study of five first time mothers who had a cesarean delivery upon maternal request (CDMR) in New Zealand. Four themes emerged as to why the women chose to have a cesarean birth: vaginal birth as hazardous, safety of the unborn child, feelings of guilt, and the right to choose. The participants had determined a vaginal birth to be hazardous and unpredictable based on stories shared by family and friends. These women felt that a more technologically advanced method was a safer alternative to a vaginal birth. Despite their beliefs in elective cesarean these women felt guilty because they were not having a vaginal birth, what is perceived by many to be the normal method. Despite these feeling of guilt the women felt it was their right to choose their method of birth. These women's views were supported by legislation in their home country of New Zealand. The results of this study indicate these women were motivated to request a cesarean by their negative perception of a vaginal delivery as uncontrollable and physically and emotionally dangerous (Arthur & Payne, 2005).

Similar views were found in another descriptive qualitative study. Weaver and Statham (2005) interviewed 44 women from the United Kingdom about their thoughts about cesarean and the factors influencing the decision. The majority of women felt a cesarean was warranted because they believed it to be a safer delivery option for themselves and their babies. This belief was further supported by images of birth in the media. Those women who requested a cesarean reported changing their minds many times as they were afraid of both the operation and a vaginal

birth. Other women (41%) who had a planned cesarean felt pressured by their physicians and had agreed to the surgery reluctantly (Weaver & Statham, 2005).

In a similar descriptive qualitative study assessing motivating factors four themes emerged from the interviews of 14 primipara Australian women: vaginal birth: frightening, unpredictable and dangerous; birth: only about ‘getting’ a baby”; caesarean section: offering safety, control and calm; and ‘switching off’: reassigning the risks associated with cesarean section (Fenwick et al., 2010). The main reason the participants had requested a cesarean was because of a fear of delivering vaginally. The women could not conceive how they could deliver a baby vaginally without suffering extreme physical damage to themselves. Stories of childbirth experiences from family and friends helped to support these fears. These women did not value a vaginal delivery as an important life process but rather viewed birth as a means to an end. These women believed a cesarean birth to be a safer, preferable method of delivery, which occurred, in a controlled calm environment. Participants reported feeling supported by and even encouraged by their physicians to have a cesarean birth (Fenwick et al. 2010).

Similar results were found in three studies that quantitatively explored motivating factors for a planned cesarean (Nerum et al., 2006; Robson et al., 2008; Wiklund, Edman, & Andolf, 2007). Robson et al. (2008) conducted a survey of 78 first time mothers who underwent a maternal-request cesarean. The main reason women requested a cesarean was because of concerns about risks to the baby with a vaginal delivery. A majority (80%) of the women was satisfied with their decision and 87% of them reported they would not try a vaginal delivery in the future.

Wiklund et al. (2007) surveyed 91 primipara women in Sweden who requested a cesarean birth. The surveys were developed by the researchers and administered upon registration to the

study, 2 days after delivery, and 3 months postpartum. The most frequently reported reason (46%) was fear over risks to the baby. Other frequently listed reasons for the request included: the women were afraid of lack of labor support, loss of control, pain, and physical injury to self. A majority (80%) was satisfied with the birth experience and 87% reported they would not try a vaginal delivery in the future (Wiklund et al., 2007).

Nerum et al. (2006) addressed the issue of fear in his study with questionnaires 2 to 4 years after the birth. Eighty-six pregnant Norwegian women, who planned a cesarean birth because of their fear of labor, were provided individual prenatal counseling sessions (Nerum et al., 2006). The majority (86%) of the women changed their preference to vaginal delivery after the counseling sessions. The majority of women who had vaginal births (93%) would prefer the same method of delivery in the future. Among the women who had a cesarean birth, 46% did not want a repeat cesarean with subsequent pregnancies (Nerum et al., 2006).

According to these studies the overwhelming factor in women's decision to have a cesarean birth is fear. Women were fearful of a vaginal birth either because of the effects on their body or for the safety of the baby. Women viewed a cesarean birth as a safer delivery alternative.

Satisfaction

The birth itself is the next step in the overall experience and is examined in this part of the literature review. All but two of the studies, Kealy, Small, and Liamputtong (2010) and Redshaw and Hockley (2010), in this category are quantitative in nature. The second category of the literature review is satisfaction. This category is further divided into the following subcategories: satisfaction with birth method, satisfaction with care, predictors of satisfaction, and negative birth experiences.

Satisfaction with birth method. In a study comparing first-time mothers' satisfaction with birthing methods, Blomquist, Quiroz, MacMillan, McCullough, and Handa (2011) evaluated 160 American women who planned a vaginal birth and 44 mothers who planned a cesarean birth. Three separate questionnaires were used; the first questionnaire, developed by the researchers, was given during the third trimester and obtained demographic data as well as planned route of delivery. The Salmon Questionnaire (Salmon & Drew, 1992) was given within 4 days of delivery and again at 8 weeks postpartum to assess the women's impressions of their births. The Salmon Questionnaire is a 20-item instrument that assesses fulfillment, distress, and difficulty. Each item is rated on a 5-point scale ranging from not at all to extremely. Higher summative scores signify higher levels of fulfillment, distress, and difficulty. Women who had a planned cesarean birth had higher levels of satisfaction and fulfillment and reported their birth to be less distressing and difficult than women planning a vaginal birth. These results could be due to the fact that of the 160 women who planned to have a vaginal birth, 48 resulted in unplanned cesarean births. There was no significant difference found between those women who delivered by planned cesarean and those who delivered by planned vaginal birth.

Similar results were found in a study conducted by Schindl et al. (2003). This study compared the birth experience of 484 women who had spontaneous vaginal deliveries with those of 147 women who had an elective cesarean. The women completed questionnaires at 38 weeks gestation, 3 days postpartum and 4 months postpartum. The assessments included a visual analog scale for pain, a mood assessment, the Salmon Questionnaire (Salmon & Drew, 1992), and semi structured interviews. Those women who had an elective cesarean birth experienced significantly lower rates of complications than those women who delivered vaginally. Furthermore, there was no difference reported in the mood of those women who had planned cesareans versus those

women who had spontaneous vaginal deliveries. In addition women who had requested a cesarean birth reported very positive expectations and experiences of their births. In fact, 74.3% of the women with elective cesareans and 66% of the women who had medical reasons for their cesarean would chose to have a cesarean birth with subsequent pregnancies (Schindl et al., 2003).

In a similar study comparing birthing methods 6,421 Canadian women were surveyed (Chalmers et al., 2010). The sample consisted of 73.7% of women who delivered vaginally, 13.5% delivered by planned cesarean and 12.8% who delivered by unplanned cesarean. Those women who had a cesarean birth were significantly less likely to have held their baby within the first hour after delivery. Once the mothers were able to hold their infants they were less likely to be skin to skin. Although the rate of breastfeeding initiation was similar for vaginal deliveries and cesarean births, women who delivered by cesarean were less likely to have initiated breastfeeding within the first two hours of life. Furthermore, babies delivered by cesarean were less likely to still be breastfeeding months after delivery. The results indicate the women who had a cesarean birth were less satisfied with mother-infant contact experiences, less likely to continue breastfeeding, and less satisfied with their birth experience than the women who had vaginal births (Chalmers et al., 2010).

Stadlmayr et al. (2004) also examined the influence of mode of delivery on the birth experience. A sample of 251 women who were between 48-96 hours postpartum was evaluated with the Salmon's item list- German language version (SIL-Ger) (Stadlmayr et al., 2001). The majority (63%) of the sample was first time mothers and 72% had a vaginal delivery. Only 11% of those surveyed had a cesarean birth. The results indicated the mode of delivery impacts the emotional experience with those women having an elective cesarean experiencing more negative

emotions postpartum than those women having a spontaneous vaginal delivery or an instrument assisted vaginal delivery (Stadlmayr et al., 2004).

These studies provide conflicting results. Some studies reported higher levels of satisfaction and lower levels of complications than those women who had vaginal births. Other studies found decreased levels of satisfaction, especially with maternal-infant contact time, and more negative postpartum emotions. These conflicting results may be due to the inclusion of vaginal births as well as planned and unplanned cesarean births.

Satisfaction with care. Wilde-Larsson, Sandin-Bojö, Starrin, and Larsson (2011) used an instrument to evaluate the quality of care during birth in Sweden. Data were collected using the Intrapartal-specific Quality from the Patient's Perspective questionnaire (QPP-I) (Wilde-Larsson, Larsson, Kvist, & Sandin-Bojo, 2010) in addition to a six-point response scale assessing six feelings including: sense of control, security, pride, receiving positive attention, failure (shame), and feeling ignored. A total of 739 women participated in the study although the majority of women had vaginal deliveries: only 30 (4%) women had planned cesarean births and 47 (6%) women had emergent cesarean births. More negative feelings and perception of care were associated with those women having cesarean birth (Wilde-Larsson et al., 2011).

Negative themes also emerged from a descriptive qualitative survey of 2960 English women conducted by Redshaw and Hockley (2010). Twenty-three percent (n=682) of the women gave birth by cesarean. Of these women 47% were planned cesarean births. The resulting themes: feelings at the time; being heard; managing communication; the illusion of choice; how it might have been different; just another new mother; wounds and hurt feelings; wasted effort in retrospect; adjusting to cesarean section; and needing to talk all reveal the influence of the quality of care on shaping a woman's perspective.

Both of these studies revealed breakdowns in communication and a lack of compassion from providers resulting in decreased levels of satisfaction. A limitation of these surveys is that all of the samples consisted of both multiparas and primiparas who had either elective or emergent cesarean births, but no distinctions were made among the results; thus limiting generalizability.

Predictors of satisfaction. Various instruments have been used to measure specific aspects of satisfaction and their predictive value. In one study 85 women who underwent elective cesarean births in the United Kingdom were assessed using the State-trait Anxiety Inventory (STAI) (Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983) and the Significant Others Scale (SOS) (Power, Champion, & Aris, 1988) preoperatively and the Maternal Satisfaction Scale for Caesarean Section (MSSCS) scale (Morgan, Halperns, & Lo, 1999) and the Recovery from Caesarean Section Scale (RCSS) postoperatively to determine if preoperative anxiety was predictive of postoperative maternal satisfaction (Hobson, Slade, Wrench, & Power, 2006). The sample consisted of 34.1% repeat cesarean, 25.9% breech presentation, 12.9% maternal-fetal health problems, and 24.7% were listed as other (including those women who requested a cesarean). The results suggest that lower preoperative anxiety was associated with higher levels of maternal satisfaction. In addition, anxiety levels were negatively associated with speed of recovery (Hobson et al., 2006).

Bryanton, J., Gagnon, A. J., Johnston, C., & Hatem, M (2008) conducted a study to identify those factors that are predictive of the quality of women's childbirth experiences. Six hundred and fifty-two women were surveyed 12 to 48 hours after birth; 43.6% of the women were first time mothers and 26.7% gave birth by cesarean, about half of which were planned cesarean births. Birth perception was measured using the Questionnaire Measuring Attitudes

about Labor and Delivery (QMAALD) (Marut & Mercer, 1979) and the Modified QMAALD (Cranley, Hadahl, & Pegg, 1983) for those women who had a planned cesarean. Results indicated that those women who had a planned cesarean birth had a more negative experience than woman who had a vaginal birth or an emergency cesarean. Awareness of events, being with the infant, helpfulness of the partner, degree of relaxation, and degree of control were all predictors of experience. Factors specific to planned cesarean births were degree of fear, satisfying feelings during the birth, and nursing support (Bryanton et al., 2008).

The research indicates higher levels of anxiety are negatively associated with maternal satisfaction (Bryanton et al., 2008; Hobson et al., 2006). Support from birth partners and healthcare providers have been found to lower anxiety levels (Bryanton et al., 2008). Nursing interventions should focus on eliminating anxiety-producing factors.

Negative birth experiences. Waldenstrom, Hildingsson, Rubertsson, and Radestad (2004) conducted a survey in Sweden of variables associated with a negative birth experience. The surveys were administered prenatally, at 2 months postpartum, and again at one year after the birth. The prenatal questionnaire contained questions about demographics and obstetrical data. The 2 month postpartum questionnaire contained questions about prenatal and intrapartal care as well as satisfaction with care. The final questionnaire evaluated the women's experiences of pain and control during birth as well as infant outcomes. Of the 2541 women who participated 44% were first time mothers. The results indicated 7% of the participants had reported a negative birth experience one year after delivery. Statistically significant risk factors associated with experiencing a negative birth included having an emergency cesarean, lack of control during birth, inability to participate in decisions about care, and lack of support from the obstetrician during birth.

Wiklund, Edman, Ryding, and Andolf (2008) also examined negative birth experiences. The Wijma Delivery Expectancy/Experience Questionnaire (W-DEQ) (Wijma, Wijma, & Zar, 1998) was administered before and after delivery. The sample consisted of 496 first-time mothers, 264 women planned a vaginal delivery, 104 had a cesarean birth on 'mother's request', and 128 women had a cesarean birth for breech position. Women who requested a cesarean birth were found to have more negative expectations of a vaginal delivery and higher levels of fear of childbirth than the other groups of women. There was no statistically significant difference in birth experiences between the spontaneous vaginal deliveries and the two cesarean birth groups.

In a similar study 65 women who underwent a planned cesarean birth and their birth partners were surveyed before, during and after the surgery (Keogh et al., 2006). The reasons for the planned cesarean included: advice of obstetrician (40%), complications with previous delivery (24%), safer for the unborn child (23%), fear of pain and childbirth (6%), and other (7%). Of the 65 participants 37% were first time mothers, for 43% of the other women this was their first cesarean delivery. The women and their partners were evaluated using a modified version of the Expectation and Experience of Birth Scale (Slade, Macpherson, Hume, & Maresh, 1993), the Anxiety Sensitivity Index (Reiss, Peterson, Gursky, & McNally, 1986), and the Short form McGill Pain Questionnaire (Melzack, 1987). Findings indicated that negative maternal prenatal expectations increased her fear response during the surgery. Additionally findings supported that fears of the birth partner may increase the negative maternal experience during and after the surgery (Keogh et al., 2006).

Porter, Van Teijlingen, Chi Ying Yip, and Bhattacharya (2007) surveyed 1238 women in Scotland who had a cesarean birth to explore the stressful factors in relation to their cesarean birth. Forty-two percent (n=521) of the respondents provided reasons for their distress resulting

in 1136 comments being content analyzed. Seventy-nine percent of the women had an emergency cesarean birth. Women who rated their birth as poor or very poor provided 38% of the comments. Women who rated their birth as good or very good provided Thirty-four percent of the comments. The majority of women (66%) reported poor communication as the most distressing factor. Difficulty bonding with their baby, lack of control, and feelings of having missed an important life experience were other distressing factors that led to a negative birth experience (Porter et al., 2007).

Another descriptive qualitative study specifically explored the recovery experience after a cesarean birth (Kealy, Small, & Liamputtong, 2010). Thirty-two women who had had at least one cesarean birth were interviewed about their recovery experience. Analysis resulted in five themes: being a good mother: the difficulties following postoperative advice after cesarean birth, unexpected pain and reduced mobility, abdominal wound complications, vaginal bleeding, and urinary incontinence. The women felt frustrated and unprepared for the activity restrictions associated with a cesarean birth. The women felt the physical limitations prevented them from providing good care to their infants. Women were also surprised by the length of time they felt pain, some reporting pain months after the surgery. For some women, even those who had planned cesareans, experienced wound complications and issues with severe vaginal bleeding and urinary incontinence. These unwanted and unexpected consequences led to a negative birth experience (Kealy et al., 2010).

Factors identified as predictors of negative experiences (Bryanton, et al., 2008) were reported as reasons for a negative birthing experience (Waldenstrom et al., 2004; Keogh et al., 2006; Porter et al., 2007). Participants described lack of support from providers, increased fears of partners, poor communication and difficulty bonding as contributing to a negative birthing

experience. The literature demonstrates a need for improved communication and support from healthcare providers.

Experience

The final category of this literature review contains studies that examined the overall experience of a cesarean birth. Four studies were found (Bluml et al., 2012; Fenwick et al., 2003; Fries, 2010; Puia, 2013), only one of which (Bluml et al., 2012) was quantitative and depicted a positive experience. Bluml et al. (2012) conducted quantitative assessments and semi-structured interviews on 48 women who had a planned cesarean birth. The majority (72.9%) of women were first time mothers, although all women were experiencing their first cesarean birth. The assessments were performed around the 36th week gestation and again two to three days after the birth. The instruments included the State-Trait Anxiety Inventory (STAI) (Spielberger et al., 1983), the Brief Symptom Inventory (BSI) (Derogatis & Melisaratos, 1983), and the Edinburgh Postnatal Depression Scale (EPDS) (Cox, Holden, & Sagovsky, 1987). The women were also asked to rate their anxiety and pain using the visual analogue scale (VAS). The interviews lasted between 30 and 40 minutes and were reported to have been analyzed using qualitative content analysis; however the results did not include any rich data from the participants but rather appears to be quantitative content analysis as results are reported as frequencies of responses.

The results indicated that only half the women felt adequately informed about the cesarean procedure, despite receiving educational material and information from their providers. Concern for the safety of the infant was one of the aspects of surgery that produced the highest levels of anxiety. Other frequently mentioned worries were anesthesia and possible complications. Feeling anxious during the surgery was reported by 83.3% of the women. The support of partners was said to be most helpful by 68.8% of the women. After the surgery levels

of depression and stress were low. Only 12.5% of the women felt the surgery was worse than what they had expected. In general, the majority (81.3%) of women was satisfied and would recommend a cesarean birth to others (Bluml et al., 2012).

Strikingly different descriptions associated with birth were expressed in three qualitative studies (Fenwick et al., 2003; Fries, 2010; Puia, 2013b). Fenwick et al.(2003) surveyed 59 women from Australia and North America who either had a cesarean birth or a vaginal birth after cesarean (VBAC). The survey, designed by the organization Birthrites, consisted of 22 open and closed ended questions to identify women's perceptions of their birthing experience. A majority of the women (78%) reported their cesarean as traumatic and very disappointing. Content analysis revealed six major themes: being supported; violated expectations; loss of control; health professionals' language, attitudes and care practices; the labor experience and the cascade of intervention; and surgical birth and the separation from the baby. Being consulted and treated with respect was an important part of feeling supported and contributed to the positive theme. The other themes were predominantly negative in nature. The theme of violated expectations was related to feelings of failure because of the inability to deliver vaginally. Women reported feeling ignored and disrespected by health care providers. Separation from their infant during the surgery further promoted negative feelings. The results of this study indicate the negative emotional impact cesarean birth may have on some women.

Fries (2010) also conducted a phenomenological study in the United States about the experience of cesarean birth, except her sample included only African American women who had an unplanned cesarean birth. The sample consisted of seven women, six were first time mothers and the seventh woman had had a previous vaginal delivery and an unplanned cesarean. Analysis of the interviews resulted in five themes: preparing for childbirth, mistrust, feeling

rushed, being fearful, and sacrificing. Women reported using advice from family and friends, television shows, and previous experiences to form expectations of childbirth. Poor communication between health care providers and the women led to feelings of mistrust. Many of the women described a sense of being rushed to make a decision. During the surgery women were fearful about the anesthesia, pain, their life and that of their baby. Most of the women described sacrificing their own wishes for the benefit of the baby. The resulting themes express an overall experience of sadness and disappointment (Fries, 2010).

In a recent metasynthesis (Puia, 2013) that explored the experience of women having a cesarean birth, only 10 qualitative studies had been conducted between the years 2000 and 2010. These studies were from a variety of disciplines and countries. Analysis of the data resulted in six overarching themes: scared to death, in your hands, out of control, broken body and soul, empty heart and arms, and shattered dreams. In the theme scared to death the women were forced to deal with many fears including fear of labor, pain, birth (either vaginal or operative), as well as fear for her own life and that of her unborn child. The second theme, in your hands describes the reliance of women on healthcare providers for good communication, information, and support. These interactions can affect the woman's view of her childbirth. The theme out of control relates to the women's feelings of disempowerment and lack of control when having a cesarean either planned or unplanned. In the theme broken body and soul women described feeling like a failure as a woman and a mother because of the need for a cesarean birth. Empty heart and arms depicts the women's difficulty bonding with their infants because of the physical nature of the cesarean birth. Finally in the theme shattered dreams women describe their feelings of shock and disbelief at the need for a cesarean birth. The results overall depicted a very negative experience of cesarean birth. A limitation of this study is that it may not be generalized

to women in the United States as only two of the studies took place in this country. As with many of the other studies mentioned in the literature review, the metasynthesis consisted of an unspecified number of multiparas and primiparas and included emergent and elective cesareans as well as those women having vaginal births after cesareans (VBAC).

The majority of studies that examined women's experiences of a cesarean birth included planned as well as emergent cesarean births. The sample criteria may contribute to the extremely negative experiences reported. Poor communication, fears, difficulties bonding with the baby were found to be contributors to a negative birthing experience.

Conclusion

In a review of the literature no studies were found that focused on first time mothers' experiences of a planned cesarean birth. A majority of the studies were focused on planned cesareans, but they were due to patient request. Patient request cesarean has been shown to be a relatively small percentage of cesarean births. More typically a planned cesarean occurs due to medical reasons. These differ from patient requested cesareans because in the case of medical reasons the woman may not wish to have a cesarean but will do so for her safety and that of her baby. These differences in reasons may impact the woman's perception of her birth.

Despite the large number of cesarean deliveries every year in the United States, a review of the literature reveals very few studies have explored women's overall experiences of cesarean birth in this country. Most of the studies occurred in Europe and Australia, with a few in Canada and only six in the United States. Many of the studies were quantitative in nature. Other studies have explored birthing experiences but they have included both primiparas and multiparas who had vaginal deliveries as well as planned and unplanned cesarean births all within the same study thus making it difficult to determine if the results are applicable specifically to primiparas

undergoing planned cesarean births. A review of the literature identified a gap in the state of the science on planned cesarean births of first time mothers.

The overall picture portrayed by the literature of planned cesarean births is one of negative experiences. Women's fears of labor, vaginal birth, and safety of the baby impacted their decision to have a planned cesarean birth (Arthur & Payne, 2005; Fenwick et al. 2010; Nerum et al., 2006; Robson et al., 2008; Weaver & Statham, 2005; Wiklund et al., 2007). Poor communication, lack of support from providers or spouse, and difficulties bonding with the infant led to decreased levels of satisfaction (Bryanton et al., 2008; Chalmers et al., 2010; Fenwick et al., 2003; Fries, 2010; Keogh et al., 2006; Porter et al., 2007; Puia, 2013b; Redshaw & Hockley 2010; Stadlmayr et al., 2004; Waldenstrom et al., 2004; Wilde-Larsson et al., 2011). The literature supports the need for further studies to improve the experience of first time mothers who have a planned cesarean birth.

Chapter three presents a detailed description of the research method. The research design is explained including a description of narrative analysis, structural versus thematic approaches to narrative, and the sample. The procedure is described including the protection of research participants, data collection method, and data analysis. The chapter concludes with a discussion of the methods used to ensure the rigor of the research.

Chapter Three: Method

A detailed description of the research method utilized in this study is offered in Chapter three. This section will provide an explanation of the following areas: the research question, research design, sample, procedure, protection of research participants, data analysis, theoretical framework, and methods to ensure research rigor.

Research Question

The research question for this study was: “What is the overall experience of a planned cesarean birth (either for medical or social reasons) including the entire birthing process; beginning with the preceding factors that influenced first time mothers to have a planned cesarean birth, including the physical and emotional experience of the birth itself, and concluding with the postpartum period and complete recovery?”

Research Design

Narrative Analysis

Narrative analysis is a type of qualitative design in which the participants’ story is the object of inquiry. These narratives are stories told by the participants about experiences in their lives. Telling a story allows the narrator to make sense of events and actions in one’s life (Riessman, 1993). Narrative analysis uncovers not only what was told, but also the way in which the story was created and the cultural context in which the story was developed (Riessman, 1993). This focus on narrative form, “... adds insights beyond what can be learned from referential meaning alone (Riessman, 2008, p.77).” Bruner (1991) further explains that it is through the development of narratives that the individual creates meaning to events of life. Labov (1997) explains that events that have entered into the speaker’s narrative are emotionally and socially evaluated and thus are transformed from experience to meaning making events.

Individuals often create narratives about experiences where there was a contrast between the ideal and reality; these often include difficult life transitions or traumatic events (Riessman, 1993). In addition to individual life meaning, narrative research further reveals the present day culture of the society in which the story was framed (Duffy, 2007). Duffy (2007) explains, “Narratives reveal, sometimes consciously and often unconsciously, the meanings, conventions, dominant beliefs and values of the time and place in which a person lives and develops an identity (p.402).”

According to Riessman (1993) “... because they are essential meaning-making structures, narratives must be preserved, not fractured, by investigators, who must respect respondents’ ways of constructing meaning and analyze how it is accomplished” (p.4). In other qualitative methods of analysis the narrative is broken into categories or “... are distilled into coding units by taking bits and pieces- snippets of an account often edited out of context” (Riessman, 2008, p. 12). Riessman (2008) argues that analyzing the narratives as a whole allows the researcher to honor the individuals’ intentions.

A researcher may choose from a variety of methodologies from which to analyze a narrative. The style of the narrative will dictate the analytic approach to be used (Polit & Beck, 2012; Riessman, 2008). The following two sections will discuss a variety of approaches to narrative analysis.

Structural Approaches to Narrative

While the structural approach is concerned with what was said in the narrative, there is a greater focus on how it was said. There are three commonly used structural approaches to narrative analysis including those of Burke (1969), Labov (1972), and Gee (1991). Burke’s (1969) structural approach to narrative analysis focused on pentadic dramatism. Burke’s (1969)

pentadic dramatism includes five key elements of a story: act, scene, agent, agency, and purpose (p. xv). The act explains what took place. The scene describes the situation in which the act occurred. The person who performed the act is the agent. Agency is the means or the instrument used by the agent. The purpose is the why of the act. The areas covered by the five elements of the pentad cannot be considered in isolation, as they overlap and instead are meant to be considered as ratios. Burke (1969) "... likened the terms to the fingers, which in their extremities are distinct from one another, but merge in the palm of the hand" (p. xxii). Narrative analysts can gain an understanding of behavior and human motivation by addressing the five elements of Burke's (1969) pentadic dramatism and their relationship with one another.

Bruner (1991) later modified Burke's pentad by adding a sixth element which he called Trouble with a capital T. Burke's (1969) dramatic narrative analysis is based on the imbalance between two or more of the five key elements. Bruner added the sixth element to provide more focus on the complication of imbalance. While the nature of prenatal care, childbirth, and postpartum recovery lends itself to the five elements of pentadic dramatism by addressing what was done (act), when or where it was done (scene), who did it (agent), how he did it (agency), and why (purpose) the data did not reveal any imbalances between the elements and as such this approach was inappropriate for this study.

Another structural approach is that of Labov (1972) who focuses on the components of the narrative. Labov (1972) believed a "fully formed" narrative consisted of six common elements: the abstract (summary), the orientation (time, place, situation, and participants), complicating action (sequence of events), evaluation (significance of the action), resolution (what finally happened), and coda (returns the perspective back to the present). Labov believes a narrative should be centered on a single topic and temporally ordered. In this method narrative

segments are identified as one of the components of the narrative and then the relationships of the components to one another are analyzed. The women's narratives in this study involved shifts in time, as they would remember other events related to the birth. The narratives also included multiple actions, evaluations, and resolutions as the stories occurred from pregnancy through delivery and recovery. Labov's approach was not an appropriate method of analysis for this study, as the women's narratives did not meet Labov's definition of a story.

The third most commonly used structural analysis method is that of Gee (1991). Gee's (1991) method also focuses on what is said, but it does so by analyzing the spoken word. Changes in pitch, volume, pauses, and punctuation are considered. The text is broken into a hierarchy of meaning units called lines, stanzas, strophes, and parts. Lines that have similar patterns form stanzas. Stanzas are the building blocks of lengthy stories. Strophes are related pairs of stanzas. The combinations of strophes make up the story and are called parts. Since Gee's method of analysis focuses on the audio component of the story and some of my data were obtained only through writing this methodology was also inappropriate for this study.

Thematic Analysis of Narratives

While structural analysis focuses on how the story was told, thematic analysis focuses exclusively on what was told; little attention is given to language and form (Riessman, 2008). Instead the narrative is analyzed as a whole. Data are interpreted based upon prior theory. Stories are kept intact by theorizing from the entire story rather than from component themes. The aim is not to generalize to the population but to interpret the meaning and to develop a theoretical argument (Riessman, 2008). Riessman (1993) explains how narrative analysis "is well suited to studies of subjectivity and identity" (p. 5). The subjective nature of childbirth and its importance in establishing maternal identity made narrative analysis a logical choice.

Examination of the narratives further revealed that thematic analysis fit most closely with the data of this research study and as such was used as the method of analysis.

Sample

The sample consisted of 11 postpartum first time mothers who underwent a planned cesarean birth. For the purpose of this study a planned cesarean was defined as a cesarean in which the decision was made prior to the onset of labor or labor induction. A cesarean may in fact have not been the woman's chosen method of birth. Often the terms planned, scheduled, and elective cesarean are used interchangeably. The cesarean may have been planned for medical or social reasons. The inclusion criteria were as follows: all participants must have had a birth of a live infant, must be able to read and write English and be a minimum of 18 years of age. There was no limit regarding how long ago the mothers may have given birth since research has shown that women have vivid memories of childbirth even 15 to 20 years later (Simkin, 1992; Waldenstrom, 2003). Women from any ethnic group were eligible to participate. There were no other exclusion criteria.

Both purposive and snowball sampling were used in this study. A purposive sample is defined as "a nonprobability sampling method in which the researcher selects participants based on personal judgment about which ones will be most informative" (Polit & Beck, 2012, p. 739). Additional participants were acquired through snowball sampling in which earlier participants make referrals (Polit & Beck, 2012). Participants contacted the researcher in response to an advertisement for the study or a referral from a participant. The researcher determined the participants' eligibility through clarifying questions either by phone or email prior to the participant sharing her story.

Procedure

Protection of Research Participants

Prior to initiation of the study approval was acquired from the university's Institutional Review Board (IRB). For those participants wishing to be interviewed informed consent was obtained prior to the interview. For those women who chose to write their stories the email with the attached story implied consent.

There is minimal risk to the human subjects involved in this research study. Although the women were describing the birth of their child there was a risk that details or emotions associated with the birth may cause a negative emotional response. Among the women who were interviewed some participants did become emotional; however none of the women wished to postpone the interview or withdraw from the study. The women were also reminded that due to the correspondence occurring over the Internet there was a potential risk that the participants' identity and story may not remain confidential. There were no direct benefits to the women who participated in this study. There were no costs to the participants and no compensation was provided.

Data Collection

Participants were recruited from a local pediatrician's office. An announcement of the study was placed in the pediatrician's office inviting women to participate in the study via email or interview. The recruitment flyer was also placed on the researcher's personal social media site. Additional participants were recruited through word of mouth and snowball sampling. Interested women contacted the researcher by email letting her know of their interest. The researcher then emailed the women an information sheet and directions for participating in the study. After receiving the documents the women had the opportunity to email the researcher

with any further questions or concerns. Consent was implied when the woman emailed her story to researcher.

For those women who wished to be interviewed informed consent was obtained prior to the interview. The interviews were audio taped and transcribed by the researcher. All participants, regardless of the method of response, were asked to respond to the statement, “Please describe for me in as much detail as you remember the story of your planned cesarean birth experience beginning with when and how the decision was made for you to have a cesarean birth, the physical and emotional experience of the birth itself and continuing up until the time you felt fully recovered. Please share all of your thoughts, emotions, opinions, and any specific examples you wish to share.” All participants were also asked to provide demographic information such as age, marital status, educational level, and ethnicity, as well as obstetrical information such as gestational age at the time of the decision to have a cesarean birth and gestational age at delivery.

Seven participants were interviewed in their homes per the participants’ requests. All interviews were conducted at times, which were convenient to the participants. The remaining four narratives were written by the participants and sent to the researcher via email. The narratives were written at the participants’ convenience and were not limited in length. After each mother sent her story by email, the researcher on occasion asked follow up questions to clarify a point of or to ask the woman to elaborate on a description.

Although qualitative interviews are typically conducted face to face and not over the Internet, there are many benefits to the latter. Hunt and McHale (2007) describe low cost, large geographical range of participants, and the ability to work with multiple interviews simultaneously as some of the benefits to researchers. Furthermore, email interviews allow time

for reflection on both the part of the interviewer and the interviewee and provide the participants an opportunity to say things they might not say face-to-face (Hunt & McHale, 2007). A study conducted over the Internet on birth trauma found a number of benefits for the participants as well including: experienced caring by being listened to and acknowledged, provided a sense of belonging, helped to make sense of their birth trauma, helped to let go of their traumatic experience, felt empowered, allowed women to help other women, and provided the women a voice (Beck, 2005).

While Internet interviews pose many benefits some limitations must be considered as well. Not all participants may have access to the Internet and a computer. Availability of resources may limit the sample to those of higher socioeconomic status. Finally women suffering from postpartum mood disorders may be less likely to respond to Internet interviews. The time constraints of caring for an infant may also discourage some women from participating via the Internet. Allowing the women an option to participate via the Internet or in person may increase participation since the women can choose the means they are most comfortable with. Furthermore use of both Internet and in person interviews in this study allowed for the triangulation of data which allows for a more “accurate representation of reality” (Polit & Beck, 2012, p.745).

Data Analysis

Reissman’s (1993, 2008) method of thematic narrative analysis was used to interpret each story as a whole. Riessman (2008) explains that in order to keep a story intact the researcher must “theorize from the case rather than from component themes (categories) across cases” (p.53). Each narrative is interpreted within a theoretical framework. The researcher analyzed one interview at a time within the theoretical framework of Roy’s Adaptation Model (RAM) (Roy &

Andrews, 1999) to identifying relevant events, main points, and common underlying assumptions to determine thematic categories and a theoretical argument. After each of the narratives was analyzed individually, they were examined collectively for commonalities among thematic categories. Particular narratives were chosen to exemplify general patterns. From these commonalities the researcher then created "... a metastory about what happened by telling what the interview narratives signify, editing and reshaping what was told, and turning it into a hybrid story..." (Riessman, 1993, p.13).

Qualitative researchers aim to depict the experiences of others' through interpretation and representation of experiences. Researchers don't have access to the actual event only the narrator's imitation of the experience (Riessman, 1993). According to Riessman (1993) there are five levels of experience involved in narrative analysis. The levels are as follows:

1. Attending: consciously reflecting on and giving notice to certain phenomena.

The participant makes an active decision to acknowledge certain aspects of the story as important and in doing so creates a new reality.

2. Telling: the participant recounts the events of an experience. The participant describes the setting, characters, and plots in order to share his/her interpretation of the experience with others. Meaning is created at this level through a process of interaction between audience and narrator. The listener asks questions to clarify certain points and increase understanding. Meaning may also shift as the story is related to different audiences. In telling the participant not only creates meaning but also creates an image of how she/he wants to be known by others.

3. Transcribing: the participant's story is recorded either through audio or video. Transcription is an interpretive process in which the researcher transforms the spoken language

into the written text. The researcher must decide what parts of the story and how much to include as well as establishing boundaries of the narrative.

4. Analyzing: the researcher analyzes each narrative separately. A theoretical framework serves as the basis for analysis. Thematic categories are identified within each story. The stories are then analyzed collectively for similarities. The researcher to share the stories and their significance then creates a “metastory”.

5. Reading: the final level of representation of experience. Drafts of the “metastory” are shared with colleagues or the participants themselves for review. Feedback may be incorporated into the final report. As others read the final product they each bring their own meaning to the narrative.

Theoretical framework. A crucial piece of narrative analysis is the use of a theoretical framework with which to guide the inquiry. According to Fawcett (2005) the research method should be congruent with the philosophical assumptions of the theoretical framework. For the purpose of this research the Roy Adaptation Model (RAM) (Roy & Andrews, 1999) was utilized. The philosophical assumptions of the RAM are founded on the principles of humanism and verativity. “Humanism is the term used for a broad movement in philosophy and psychology that recognized the person and subjective dimensions of human experience as central to knowing and to valuing” (Roy, 1988, p. 29). Roy (1988) created the term verativity and defines it as “... a principle of human nature that affirms a common purposefulness of human existence” (p.30). The five philosophical assumptions of the RAM are as follows:

1. Persons have a mutual relationship with the world and God.
2. Human meaning is rooted in an omega point convergence with the universe.

3. God is ultimately revealed in the diversity of creation and is the common destiny of creation.
4. Persons use human creative abilities of awareness, enlightenment, and faith.
5. Persons are accountable for the processes of deriving, sustaining and transforming the universe (Roy & Andrews, 1999, p. 35).

The nature of qualitative research is to explore the subjective nature of people's experiences and thus is congruent with the philosophical assumptions of RAM. Roy's Adaptation Model (Roy & Andrews, 1999) is one of the most commonly used theories in nursing research and has been previously used in research to explore women's adaptation after childbirth (Abner, Weiss, & Fawcett, 2013; Aktan, 2010; Weiss, Fawcett, & Abner, 2009; Fawcett et al., 2011). The purpose of research guided by RAM is to further the understanding of how people adapt to environmental stimuli and how nursing can improve the adaptive process (Roy, 1988).

According to Roy (2009) adaptation is defined as "the process and outcome whereby thinking and feeling people, as individuals or in groups, use conscious awareness and choice to create human and environmental integration" (p. 26). A planned cesarean birth deals with the adaptation to an alternate birth method and to the physical and emotional effects of a cesarean. These adaptations made Roy's Adaptation Model seem like a logical fit for the data in this study. As such, Roy's Adaptation Model is the theoretical framework in which the data analysis for this study occurred.

According to this model a person is an adaptive system that interacts with environmental stimuli (Roy & Andrews, 1999). Environmental stimuli consist of focal, contextual, and residual stimuli. A focal stimulus is the internal and/or external stimulus that is most immediately threatening the person, in the case of this research the focal stimulus would be the planned

cesarean birth. The contextual stimuli are all the other stimuli that contribute to the adaptation; in the case of this research this would include demographic information (age, race, marital status, and education).

Regulator and cognator subsystems are the methods through which an individual responds to stimuli (Roy & Andrews, 1999). The regulator subsystem is the neurological, chemical, and hormonal response to stimuli and was not considered in this research. The cognator subsystem consists of four cognitive-emotive channels which include the following: perceptual/information processing, learning, judgment, and emotion (Roy & Andrews, 1999). Roy and Andrews (1999) defined perception as “the interpretation of sensory stimulus and the conscious appreciation of it” (p.259). In this study, the women’s perceptions of their birth experience represented the cognator subsystem and included thoughts and emotions about a planned cesarean, the birth itself, and the recovery. Providers, support systems, and feeding issues provided additional details in the women’s descriptions about knowledge level, information provided, and care received.

According to the RAM the regulator and cognator coping processes are represented by four modes of adaptation; physiological-physical, self-concept-group identity, role function, and interdependence mode (Roy & Andrews, 1999). The physiological mode consists of the physical and chemical processes involved in human function. For a woman who had a cesarean birth this includes things like fatigue, pain, and decreased mobility. The self-concept-group identity mode is the emotional aspect, including feelings about oneself and the perception of others reactions. Role function is the functional status of the person after exposure to the stimulus. In the case of this research role function would refer to the woman’s ability to perform as wife and mother after exposure to the stimulus of a planned cesarean birth. The interdependence mode focuses on

development of satisfying relationships between the individual and significant others, such as a spouse or infant, and the receipt of social support. A basic premise of the RAM is that all of the four adaptive modes are inter-related; a behavior in one mode may affect another mode (Roy & Andrews, 1999). The conceptual-empirical-theoretical structure for this study is illustrated in Figure 1.

A person continually experiences environmental stimuli and must make an adaptive response. The response may be classified as either adaptive or ineffective (Roy & Andrews, 1999). Ineffective responses indicate a need for nursing interventions. How well the woman adapts to childbirth, and specifically a planned cesarean birth in this study, is a function of the stimulus she is exposed to and her adaptation level.

Methods to Ensure Research Rigor

Research is often evaluated in terms of validity. Validity refers to "... the degree to which inferences made in a study are accurate and well-founded..." (Polit & Beck, 2012, p. 745).

Qualitative researchers have long argued that since qualitative research is founded in different epistemological and philosophical beliefs then quantitative research that validity is an inappropriate criterion by which to evaluate qualitative research. Riessman (2008) explains that there are two important levels of validity when conducting narrative research "... the story told by the research participant and the validity of the analysis, or the story told by the researcher" (p. 184). Riessman (1993) argues, "a personal narrative is not meant to be read as an exact record of what happened..." (p. 64) and therefore should be evaluated using different standards.

Riessman supports the use of the term "trustworthiness" in narrative research instead of validity. Riessman (1993) explains that validation is "... the process through which we make claims for the trustworthiness of our interpretation..." (p. 65). Different narratives may be

constructed by the same individual and about the same event depending on the values of the narrator, the audience, and the social context at the time. There are four methods of approaching trustworthiness in narrative research, these include: persuasiveness, correspondence, coherence and pragmatic use Riessman (1993).

Persuasiveness

Riessman (1993) explains, "... good narrative research persuades the reader" (p.191). The researcher is able to convince the reader the interpretation of the narrative data is reasonable, credible, and compelling. Evidence from the participants' narratives helps strengthen the researcher's theoretical claims. Riessman suggests audio taping interviews so that the participants' exact words may be used. Persuasiveness is further strengthened when alternative interpretations are considered. Another means of strengthening persuasiveness is to keep an audit trail of the analytical process. Detailed documentation of the data collection and analysis allows for transparency in how the researcher arrived at the interpretations and thus the argument becomes more persuasive. Finally, the level of persuasiveness is ultimately determined by the quality of the researcher's writing style. Researchers must choose the most suitable form in which to present the results of the narrative analysis. Reissman (2008) argues that the level of persuasiveness is judged by how much the story moves the reader and gets one to think differently about a phenomenon.

The nature of childbirth itself and the emotional component makes for compelling narratives. The narratives in this research were either written by the participants or recorded and transcribed to allow for the use of the participants' exact words to support the researcher's claims. The recruited participants represented a variety of cases allowing alternative interpretations to be considered. A detailed description of the data collection and analysis

methods for this study was included in the final report further adding to the persuasiveness of this research.

Correspondence

Another approach to trustworthiness, according to Riessman (1993), is correspondence. This involves sharing the research findings with the participants of the study (Riessman, 1993). Riessman (1993) explains, “It is important that we find out what participants think of our work, and their responses can often be a source of theoretical insight” (p. 66). Lincoln and Guba (1985) believed the credibility of qualitative research is enhanced if the results are viewed by the participants as adequate representations of their stories. Credibility is defined as, “confidence in the truth of the data” (Polit & Beck, 2012, p. 724). However, Riessman (1993) questions whether the participants can in fact establish validity of the researcher’s interpretations. Riessman (1993) explains, “Human stories are not static, meanings of experiences shift as consciousness changes” (p.66). Riessman (1993) further cautions that the individual participants do not have access to all the narratives and therefore may not be able to adequately evaluate the researcher’s theorizing across cases. In the end the final product is the work of the researcher and he/she must take responsibility for its truthfulness.

In this study correspondence occurred when the narratives were returned to the participants for validation. Participants were contacted by email or phone to determine if they would be willing to review the results. Five participants agreed to the researcher’s request to validate the results. The preliminary results were emailed to those participants. All five participants concurred that the results reflected their experience of a planned cesarean birth as a first time mother. Participants reported feeling that their experience was accurately portrayed. One participant shared, “So many of the respondents have so many of the same

thoughts/experiences as me. If only I knew then what I know now.” This study further achieved trustworthiness by employing correspondence with the research participants.

Coherence

A third aspect of trustworthiness is coherence. Agar and Hobbs (1982) described three kinds of coherence: global, local, and themal. Riessman (1993) defines global coherence as the narrator’s main objective in telling the story, such as to recount a past event. Local coherence is what the narrator is trying to do within the narrative itself. This is often accomplished through use of certain literary devices, such as contrasts, metaphors, and juxtaposition. Thematic coherence involves the content of the narrative, specifically the presence of prominent themes that appear repeatedly within the narrative. Riessman (1993) emphasizes that, “... coherence must be as ‘thick as possible, ideally relating to all three levels’” (p. 67). Agar and Hobbs (1982) agreed stating, “... if an utterance is shown to be understandable in terms of the three kinds of coherence, the interpretation is strengthened” (p. 29).

Global, local, and thematic coherence were all present in this study. The women shared their stories with the purpose of enlightening healthcare providers’ as to what the experience of first time mothers who underwent a planned cesarean birth entailed. Participants believed that through sharing their stories care might be improved to first time mothers having planned cesareans by addressing their unique needs.

Pragmatic Use

The fourth and according to Riessman (2008) the “ultimate test of trustworthiness” is pragmatic use (p.193). Riessman (1993) defines pragmatic use as the extent to which other scholars use one’s research as the basis for future research studies. This criterion cannot be evaluated at the time of the work but rather must be assessed in the future. While the true test of

pragmatic use will come in time as other researchers use one's work, Riessman (1993) explains how transparency can aid in pragmatic use:

We can provide information that will make it possible for others to determine the trustworthiness of our work by (a) describing how the interpretations were produced, (b) making visible what we did, (c) specifying how we accomplished successive transformations and (d) making primary data available to other researchers (p.68).

The actual pragmatic use of this study remains to be seen. However evidence has been provided upon which other researchers may evaluate the trustworthiness of this project. The review of literature revealed few studies related to the experience of first time mothers having planned cesarean births. This study will add to the limited body of research available. The narratives included in this study provide a rich description of the experience. The detailed description of the data collection and analysis procedures provided in this study may serve as a basis for others conducting similar research. While the narratives were not presented in their entirety in the final report, they were kept by the researcher for possible further review by others.

Ultimately the validity of a research study can be evaluated in many ways. Riessman (1993) argues for use of the four levels of trustworthiness. However, Riessman (2008) goes on to explain,

They are not the only ways to look at the many-sided issue of validation and, like the facets of a cut gem, angles converge at points. Each looks at the validity question from a different perspective; some angles will be relevant to certain inquiries, epistemologies, and disciplinary imperatives, and not to others (p. 185).

Despite the different methods of establishing validity, if the researcher has detailed the sound methodology used and was guided by ethical considerations and theory trustworthiness may still be established.

Summary

Narrative analysis was the methodology used in this research study. The sample consisted of 11 first time mothers who experienced a planned cesarean birth. The participants were interviewed either by email or in person. Those interviews that were conducted in person were audio taped and transcribed by the researcher. Riessman's (1993, 2008) thematic analysis was used to analyze the narratives. A discussion of how the research participants were protected was provided. The chapter concludes with a discussion of Riessman's (1993, 2008) criteria for trustworthiness used to ensure the rigor of the research. The following chapter presents the results of the narrative analysis.

Chapter Four: Results

Introduction

Chapter four provides a detailed description of the research participants in addition to the analysis of the narratives provided by first time mothers who had a planned cesarean birth.

Sample

Eleven women participated in the study; seven chose to be interviewed and the remaining four women emailed their stories. The complete set of narratives ranged from 972 words to 3393 words with the mean being 2436 words. The interviews ranged from 12 minutes 40 seconds to 40 minutes 3 seconds with the mean time being 29 minutes and 51 seconds. The cesarean births all took place on the East coast of the United States in Connecticut, Massachusetts, New Jersey or Pennsylvania. All of the participants were white, married women with college degrees; one woman had her Associate's degree and three women had either completed or were working on their Masters education. The mean age of the sample at the time the women participated in the study was 34 years (range 28-50). The mean gestational age at the time of birth was 38 weeks (range 35-40). Most of the women decided early in their pregnancy to have a planned cesarean, as the mean gestational age at the time of decision was 15 weeks. The demographics and obstetrical characteristics of the women are presented in Table 2.

Narrative One: Mary

Mary always thought she would have a vaginal delivery, but then she became pregnant with twins. From the moment she found out she was carrying twins Mary's doctor encouraged her to have a cesarean birth. "I was pretty convinced after that first visit, but hadn't decided 100% at that point." Mary turned to friends and family for advice. "My cousin had a baby when I was 3 months pregnant and had a horrible 23 hour natural birth. When I visited her in the

hospital she gave me ALL of the details which made me even more certain that a c-section was the way to go.” Other family members related positive stories of cesarean births, including Mary’s husband whose children from a prior marriage were born by cesarean. “He had a great experience so he reassured me that it (a cesarean) was a good way to go.”

Ultimately, it was Mary’s decision. “I had to choose what I was most comfortable with.” Despite Mary’s confidence in her decision she was bothered by people’s comments.

There seems to be quite a stigma associated with having a c-section when a vaginal birth is possible. I felt this stigma even being pregnant with twins...sometimes when people asked how I would give birth, I would tell them c-section and they would try to convince me to try a natural birth.

Mary would try to ignore comments like, “are you still thinking about having a natural birth?” and “it is good for a baby to go through the natural delivery process” and instead just be secure with her decision.

Despite Mary’s confidence in her decision she became increasingly emotional about her decision towards the end of her pregnancy when she realized she would not go into labor and would never know what labor felt like. These feelings continued even a year after delivery. Mary shared, “Even now sometimes when I see a woman going into labor on TV or when a friend tells me her birthing story, I feel ripped off because I never got to experience the feeling of actually going into labor and physically pushing a baby out.” Mary tried not to focus on such thoughts.

The day of the surgery was filled with emotions. Initially the day began with extreme fear as Mary recalled, “As I waited to go into the operating room, I remember my entire body was shaking uncontrollably. I cried uncontrollably from being so scared of what was about to

happen.” Mary’s fear was heightened by the anesthesia “The medication seemed to make it difficult to do anything including crying. I felt almost like I was frozen in place.” In a matter of moments Mary was brought from intense fear to intense joy as her daughters were born. Mary reflected on her daughters’ birth, “It was very emotional to hear her cry for the first time and it remains one of the most wonderful moments in my life.” Mary recounts as the babies were brought over and the first family picture was taken, “...my fear was gone and a huge sense of relief and joy filled me.”

Mary described her recovery as “seamless” as she experienced no complications or difficulties with normal activities. “I was determined to get feeling better ASAP and not be held back.” In addition to Mary’s positive attitude she also reported having a lot of support from her mother who came over every day for several months. “It gave me the help I needed and also company which was great.” Mary recounted how exercise enhanced her physical recovery.

We would go for walks and eventually it got easier and easier and my body became stronger. It probably took 2 full months before I truly felt back to “normal”. Eight weeks after the delivery I returned to the gym and my 5-day per week workouts and have been feeling “back to normal” ever since.

Mary felt fully prepared for her cesarean birth after conducting her own research and speaking with others. “My expectations of a c-section, they were fully in line with what happened.” Mary also believed her positive attitude contributed to her overall satisfaction with the experience. “I am an optimistic person so I didn’t really have any thoughts that things would go wrong... I am very happy with the choice I made and with the aftermath of it.”

The themes for Mary included:

1. Decision

- a. Doctor encouragement
 - b. Influences of birth stories
- 2. Stigma of cesarean birth
 - a. People try to change mind
- 3. Missing out on vaginal experience
- 4. Acceptance of birth method
 - a. Confidence in decision
- 5. Emotional roller coaster of birth
 - a. Fear of surgery and anesthesia
 - b. Joy
 - c. Relief
- 6. Emotional recovery
 - a. Easy
 - b. Positive attitude
 - c. Presence of support
- 7. Physical recovery
 - a. Easy
 - b. Short (2 months)
 - c. Presence of support
 - d. Physically active
- 8. Expectations
 - a. Realistic
 - b. Had prior information

9. Outcomes

a. Satisfied with choice

Narrative Two: Ellen

Ellen's journey to a cesarean birth started before conception with her infertility treatments. While at the doctor's office she learned she had a bicornuate uterus. Ellen remembered, "the conversation being immediately diverted to the risks associated with carrying a child and complications that could arise during delivery. I was devastated." Fortunately, Ellen was able to get pregnant, but she did not immediately opt for a cesarean birth. Ellen recounted, "I didn't want to have a cesarean birth. I was angry." Ellen's feelings of anger stemmed from her views of cesarean birth.

I didn't feel that it [a cesarean] was normal. I believed, to some degree, that my experience would be inadequate to those whom delivered vaginally. I had a twisted interpretation that they had to work much harder, and therefore deserved the "prize" more-the reality was I was just going to lie there.

Ellen also described feeling inadequate "...because I did not experience what other mom's do." These beliefs led to feelings of failure. Ellen was able to share her thoughts with her husband and parents and was able to come to terms with her emotions prior to delivery. However, people's comments still evoke feelings for Ellen. "To this day when people say that I didn't give birth the 'normal' way- it infuriates me."

Eventually Ellen had to discuss her birth options. At about 16 weeks the doctor presented Ellen with the options and associated risks of a vaginal birth versus a cesarean birth. Although Ellen desperately wanted to deliver vaginally she agreed to a cesarean birth. Ellen explained, "I wasn't, for even a second, going to put my baby in potential harm." Once Ellen made the

decision it allowed her to mentally prepare for the surgery. Ellen was most scared of the epidural and the potential side effects. Ellen shared, “I was scared, very scared!”

Although Ellen had a planned cesarean she was given a surprise when her water broke four weeks early. But Ellen was not alarmed by this rather she explained, “I remember the calmness that entered my body immediately after that experience- I was about to become a Mom.” Ellen described feelings of excitement as she posed for pictures and waited for her surgery. As it came time to go to the operating room Ellen’s fear returned.

I didn’t really have expectations of the cesarean. My husband and I didn’t realize that we would be separated for a short time before the procedure would begin- I remember my heart racing as I walked into the operating room. The fear grew when I walked in and saw all of the instruments on the table. I was petrified of needles and now my husband wasn’t with me!”

Once Ellen’s husband rejoined her and the surgery started Ellen’s feelings of calm and excitement returned. “The delivery was perfect - I wasn’t nervous at all- just excited to find out if we would have a boy or a girl. The doctors talked us through everything and I never felt any pain.” Soon Ellen’s daughter was born and feelings of relief overcame Ellen and her husband. “After hearing the sweet cry of our baby, and getting the nod from the NICU staff present that she was ok, we took a deep sigh of relief and cried ourselves.” Ellen’s positive emotions continued into the recovery room. “I was, well, heavily medicated! I still remember feeling like I was floating in the air. No pain. Pure joy and excitement!”

Physically Ellen recovered quickly. Ellen reported feeling great throughout her hospital stay. Once home she limited her physical activity for about a week and returned to “normal living” within two weeks. Ellen attributed her speedy recovery to the help and support of her

husband and family. “I did have help and thank God for it! My husband, Mom, Dad, and Mother-in-law were all readily available for guidance and care.” Ellen’s emotional state took a little longer to improve. “Emotionally, I felt pretty good in a few months. It was the first time I was sleep deprived like that, so that also wore on my emotions.” In the end Ellen shared, “I’m so very glad and truly blessed to be a Mom.”

The themes for Ellen included:

1. Decision
 - a. Anger about need for cesarean
 - b. Safety of baby
 - c. Medical issue but c/s not required
2. Stigma of cesarean birth
 - a. Not “normal”
 - b. Inadequacy
3. Missing out on vaginal experience
4. Acceptance of birth method
 - a. Safest for baby
5. Emotional roller coaster of birth
 - a. Fear- needles/spinal
 - c. Calm
 - d. Relief
 - e. Joy
6. Emotional recovery
 - a. Slower (2 months)

- b. Sleep deprived

7. Physical recovery

- a. Easy
- b. Short (2 weeks)
- c. Presence of support

8. Outcomes

- a. Happy to be a Mom

Narrative Three: Sarah

Sarah's cesarean birth story began at her 38-week appointment. After a routine visit and vaginal exam Sarah experienced some vaginal bleeding. The bleeding increased in intensity and Sarah had to go to the hospital to be evaluated. During this hospital visit an ultrasound was performed and the baby was found to be in the breech position. Sarah shared, "They did some routine labs and informed me of some news which at the time was upsetting to me. While Sarah was happy the baby was healthy and the bleeding was not dangerous, she was not happy the baby was breech. "I knew what breech meant. ... At this point I was pretty sure that due to fetal position and bleeding, I was going to deliver via c-section." Sarah described feeling a sense of loss when she found out the baby was breech.

I was hoping to have a natural vaginal delivery...I was sad to not have that "womanly" experience. Although I had seen the pain that women went through in natural labor, I still wanted to see what it was like and do my best to fulfill a natural approach to birth.

After 24 hours of observation Sarah's bleeding had stopped so she was sent home with a scheduled cesarean date later in the week pending that the baby was still in the breech position.

Sarah went home and attempted some positions of her own to try and rotate the baby. Sarah remembered, “I said some prayers and went to my pre-op testing hoping that my little one would flip around to the vertex position.” Unfortunately, another ultrasound revealed the baby was still breech. Sarah was offered an opportunity to have a version, a procedure in which the doctor tries to manually externally rotate the baby. Sarah had been a labor and delivery nurse and had seen such procedures performed and had also seen emergency cesareans as a result of those procedures so she opted not to have a version. Sarah and her husband decided, “... We did not want to assume those risks for a procedure that may or may not change the outcome of having surgery.” Once the decision was made Sarah recalled feeling a sense of calm as she was going in for surgery.

Having been a labor and delivery nurse and circulated on other cesarean births, Sarah knew what to expect during the surgery. Sarah recounted that her spinal was placed easily and her anesthesia was excellent. Once the baby was born Sarah described a sense of joy. “I have to say, once hearing the baby cry; I was so happy that I had the c-section because I knew the baby was delivered in the safest way possible.” Sarah shared how she was able to deal with her feelings of loss. “I think having a supportive partner, my husband, and faith in God that this was meant to be for some reason; it helped me to accept having a c-section delivery more easily.”

Sarah reported an equally good experience with her recovery. “I had some expected pain, but maintained a tolerable level on Ibuprofen.” Sarah did relate that the pain complicated breastfeeding. “I think one of the more difficult tasks for me post-op was learning to breastfeed. I had difficulty positioning our daughter efficiently and comfortably in the first few weeks after delivery.” However, Sarah was able to continue to breastfeed with the help and support of her husband and a lactation consultant. In addition to support of breastfeeding, Sarah’s husband was

home from work during those first two weeks and helped with household chores. Sarah shared that by the time she went for her postpartum visit she had returned to her prepregnant weight and had been taking short walks.

The themes for Sarah included:

1. Decision
 - a. Safety of baby
 - b. Medical need - breech
2. Stigma of cesarean
 - a. Loss of “womanly” experience
3. Missing out on vaginal experience
4. Acceptance of birth method
 - a. Faith
 - b. Support
5. Emotions of birth
 - a. Calm
 - b. Happy
6. Physical recovery
 - a. Easy
 - b. Short (8 weeks)
 - c. Presence of support
 - d. Physical activity
 - e. Breastfeeding difficulties

Narrative Four: Susan

Susan had never considered how she would give birth because she never thought she would be pregnant. Susan explained, “I had never intended to become a birth mother. I didn’t want that, Amy wanted it more than I did.” Amy and Susan both wanted a child, but the plan was for Amy to carry their child. Amy tried for many years and over 17 rounds of in vitro fertilizations (IVF), but was never able to get pregnant. Susan recounted, “...finally we got to a point where we couldn’t take the emotional roller coaster any longer and we decided together, with my initiation, that I would give it a try.” There was some concern about Susan becoming pregnant because she had previously undergone a myomectomy (uterine surgery), but with approval from Susan’s doctor she went ahead with the IVF. Susan described the treatments,

It was very painful going through the fertility to get to the point where my body could receive an embryo transfer, having to go through a lot of needles, progesterone needles to the thigh or buttock, it was very painful. At one point I asked the reproductive endocrinologist if I could cease the therapy.

On the first attempt Susan became pregnant and she remembered, “We were very happy.” Susan portrayed her pregnancy as being very uncomfortable. She suffered morning sickness for the first 20 weeks. “In the third trimester I had this big belly and was just very uncomfortable... I just so wanted to get this pregnancy over with.” Initially the doctor had thought Susan would be delivered early because of her prior surgery, but the baby was doing well so the doctor decided to wait until full term to deliver the baby. Susan was very disappointed, “I remember sitting in her office and just sobbing and crying.”

Susan knew from the moment she was pregnant that she would have a cesarean birth. “Because of my previous myomectomy surgery I knew a vaginal delivery was not an option for me. I felt fine with having a cesarean because I had undergone abdominal surgery before

without any complications.” Amy and Susan went to childbirth classes, but very little was said about cesarean birth. About 4 weeks before the surgery Susan remembers becoming very anxious about the operation. “The thing I was most anxious about was not the incision but it was undergoing the spinal and I was concerned that maybe the anesthesiologist would injure me, seriously injure me and cause paralysis... I found it difficult to shake that fear.”

The morning of the surgery Susan’s fears grew. She shared, “I remember ... waiting and having all kinds of anxiety; what if I become paralyzed, will I be able to do what I did before, and just kind of being flooded with all these fears.” Susan remembered having a friend wait with her and Amy and the distraction was helpful until it was time for Susan to go to the operating room. Amy was not allowed to go with Susan during the anesthesia. No one had prepared Susan for this; “I was surprised about that because I really wanted her with me.” As Susan was prepped for her spinal she was introduced to a student by the anesthesiologist, which further increased her concerns. Susan remembered, “So now I am even more anxious, so I had a really hard time calming down.” Susan reported the nurse trying to comfort her with no success. Susan explained,

The only thing that really helped me was thinking about my grandmother who I was very close to. She had passed away three years before and just trying to think of her presence with me and that was really what got me through.

When the obstetrician came in Susan remembered telling her, “I want you to talk to me through this whole procedure.” Susan explained, “I felt like I needed to have some kind of control over it.” Susan recalled the moment the baby was brought to her, “I said, ‘Welcome home. I have been waiting for you’ and it was great, it was a wonderful experience. We had waited many, many years for this.”

Susan remembered being in pain and uncomfortable while in the hospital, but reported her stay as uneventful. Her return home was much worse. Susan shared, “When I got home the first night was just a nightmare. I was flooded with all these emotions because the baby was just crying and crying. I remember telling Amy ‘I just can’t do this.’” Susan’s feelings of despair continued,

It was miserable because I was in pain, I was feeling very sad, and I was feeling inadequate. My body wasn’t myself. My body wasn’t allowing me to be who I was before and having this feeling of my body not allowing me to be who I was before had been going on for many, many weeks.

Susan’s feelings were compounded by difficulties breastfeeding.

It was very uncomfortable for me to have this incision, which was still healing, and nursing Emily who wasn’t nursing. I found that very frustrating. Emily just couldn’t latch on, I couldn’t hold her right, the incision was bothering me, and I just didn’t know what the hell I was doing.

Due to Susan’s prior surgery she had expectations about how her recovery would proceed after her cesarean birth. With her first surgery Susan felt better after just six weeks. She explained, “So six weeks came and I was expecting to feel better and I didn’t. I was still very weak, tired all the time, I couldn’t lift things I wanted to, I had this belly which was still very huge.” Susan’s postpartum emotions were tied to her earlier feelings during pregnancy. She explained, “It felt like the pregnancy had snatched my body away and the operation did the same thing.” Susan reported her recovery took a full year, “It took a full year before I really felt like I had regained my body back fully. My belly had gone back to its normal size and I felt healthy, fully back to the way I was pre-pregnancy.”

The themes for Susan included:

1. Decision
 - a. Cesarean only option due to medical history
2. Emotional roller coaster of birth
 - a. Anxiety
 - b. Fear-spinal
 - c. Need for control
 - d. Joy
3. Emotional recovery
 - a. Sadness
 - b. Inadequacy
 - c. Frustration
 - d. Presence of support
4. Physical recovery
 - a. Difficult
 - b. Long (1 year)
 - c. Painful
 - d. Physical limitations
 - e. Recovery from pregnancy
 - f. Breastfeeding difficulties
 - g. Presence of support
5. Expectations
 - a. Unrealistic

Narrative Five: Jane

Jane always knew she wanted a cesarean birth. “I had anxiety with the idea of giving birth vaginally, but that was outside of the circumstance for my decision though.” Jane had osteosarcoma (bone cancer) when she was younger. Due to the cancer Jane had an internal prosthetic knee. Jane was concerned that during labor with an epidural the knee could break. “So I did not want even further anxiety regarding that [the knee].” Jane actually approached her doctor early on in the pregnancy about a scheduled cesarean. At first she was told, “it was too early” to discuss it. So Jane brought it up again later in the pregnancy. “I finally asked one of my doctors... about it and she kind of blew me off, ‘No, no you’d be fine’ and I just laughed. I have no tolerance for that kind of nonsense.” Jane was unwilling to accept that behavior so she found herself a new doctor. The next doctor was much more receptive to the idea. Jane was asked by the obstetrician to get a letter from her oncologist and then the surgery was scheduled.

In preparation for the birth Jane had enrolled in a childbirth class to get a tour of the hospital and an idea of the process. Jane described the childbirth educator as being anti c-section and anti-drugs and as such got little benefit from the class. “That person was a strong advocate for natural birth without drugs so c-section was like the last thing on her radar.” Jane did not let other people’s opinion effect her decision. “I also didn’t care what she thought.” In fact, Jane continued to advocate for herself, “... we put a complaint in against the woman holding class.”

Jane was able to schedule her surgery for a day that her favorite doctor was on, so that made her happy. Jane didn’t really know what to expect. “I had minimal knowledge of a c-section. The knowledge I had came from hearing my friends’ experiences.” Through conversations with her nurse friends Jane learned that resident doctors often are the ones to perform the surgery. Jane was not comfortable with that idea so she had a conversation with her

doctor. Jane asked the doctor who would be performing the surgery. The doctor informed Jane that a team including residents performed the operation. Jane shared, “I made it very clear that that was not what I was looking for. ‘I am choosing you for your expertise so are you going to do it or not?’ And at that point he agreed.” Jane explained,

I was not comfortable with that [the resident performing the surgery]. I felt that this was probably going to be my only childbirth and it was as it turned out. I was not comfortable taking any risks where I thought it was unnecessary ... I just felt there was no room for error.

On the day of the surgery Jane remembered being calm until she got on the operating room table to do the spinal. “They struggled to get the spinal in... I was about to change my mind and say ‘forget this I can go home and wait it out.’ That was my only moment of doubt.” Jane recounted that her cesarean went well and was quick. Once Jane’s daughter was born she expressed her joy, “They brought her to me and I held her for a second on the table. That was one thing I told my husband I wanted.” Jane was thrilled as she was then allowed to spend time with the baby in the recovery room before being transferred to her room.

Jane reported no difficulties with her recovery. She was up the next day and came home three days later. Jane’s husband spent the first two weeks home with her, which was helpful. Despite an uneventful recovery Jane reported, “I started to feel better when I went back to work at about three months, but then it took me about a year before I felt back to myself.” Jane had had prior surgeries that she felt were far worse than her cesarean. Jane shared, “The recovery from the c-section was more recovery from the pregnancy for me.”

The themes for Jane included:

1. Decision

- a. Always wanted cesarean
 - b. Anxiety about vaginal birth
 - c. Empowered
 - d. Advocated for self
 - e. Medical issues but c/s not required
2. Emotional roller coaster of birth
- a. Doubt about decision
 - b. Joy
3. Physical recovery
- a. Presence of support
 - b. Long (1 year)
 - c. Recovery from pregnancy

Narrative Six: Kim

Kim found out her baby was breech at a regularly scheduled ultrasound at about 30 weeks gestation. Two weeks later, at her regular office visit, Kim asked her doctor “When do we start to worry about her not turning?” The doctor told Kim, “We start to worry now. You know chances are good she could still turn, but we are heading around the curve where we are running out of room.” After that visit Kim began to prepare herself for a cesarean birth. She conducted her own research online about a cesarean delivery as well as the possibility of a version. Kim discussed, “My doctor did offer me that opportunity [for a version] ... but we both decided that it doesn’t work all the time, you could put the baby in distress, she could turn back, and it wasn’t worth it to me.” Kim also talked with her friends about their experiences with a cesarean birth, all of which had good experiences. Kim shared, “For the most part everybody

had said you know it's [a cesarean] pretty standard, it's nothing to be worried about; so I was pretty comfortable with this is the way it's going to go."

Kim did not report having any negative emotions about not having a vaginal delivery. She explained, "Vaginal delivery was not something I was totally gung ho on. It was not something I had to do. My thought was it's 2014, she's breech and this is the safest way to bring her into this world." Kim's personality also lent itself to a planned cesarean. Kim explained, "I am a big planner so ... I was looking forward to it because I could plan my last day of work and things like that." Kim shared how her doctor explained everything to her and her husband in advance of the surgery. "So we went through everything kind of from soup to nuts, so I felt very prepared for what was going to happen."

Due to the baby's position Kim had been experiencing a lot of back pain during her pregnancy. Kim described the pain as "excruciating" making it difficult to even walk. She went on to say, "I had never been through labor before but at this point I was like bring it on because this is how much bad pain I was in. So the morning of the c-section I woke up ready to go." Kim's biggest fear about the surgery was getting the spinal anesthesia. She described how the doctor and nurse helped her through the procedure. "There was a nurse that stood in front of me the whole time, just keeping me focused. My doctor was there and she was holding my hand." Once the spinal was in Kim remembered things going very quick and easy. "Most of the time I was just starrng at the ceiling and my husband held the baby while they stitched me back up."

Once on the postpartum unit Kim reported keeping up with her pain medication and being able to manage by herself. The only regrets Kim reported were related to breastfeeding. "The only thing I wish could have gone differently was the lactation consultant information that I got while I was in the hospital." Initially Kim was not producing enough milk and needed to

supplement with formula. The information provided was not very clear and Kim wound up not supplementing as much as she was supposed to causing the baby to lose additional weight. Kim recalled thinking, “Oh my God, my child is starving!” Kim elaborated, “I wish I was better prepared. They prepare you so much for how to breastfeed, troubleshoot, and use the lactation consultant, but they don’t prepare you for what if you can’t breastfeed, that’s the only thing I wish they had done.”

Kim’s recovery continued to go well once she was at home. In the first few days at home Kim’s husband and family were there. Kim stated, “Having people here when I first came home was helpful.” However, Kim was anxious to manage on her own, “I was looking forward to understanding what normal was going to be like with just me, my husband, the baby, and the dog.” Kim immediately began exercising by walking once a day. Within a week of her surgery Kim reported walking two miles a day. Kim had reported working out four or five times a week even when she was pregnant. “I had tried to stay active because I had read a lot that being physically fit helps you in labor and your recovery.” At the time of the interview, only four weeks after delivery, Kim reported feeling only a little soreness. “I am happy I am able to do what I need to do to take care of the baby.”

The themes for Kim included:

1. Decision
 - a. Influences of birth stories
 - b. Safest for baby
 - c. Medical need- breech
2. Acceptance of birth method
 - a. No desire for vaginal delivery

- b. Need for control
 - c. Safest for baby
- 3. Emotions of surgery
 - a. Ready to go
 - b. Fear - spinal
 - c. Supportive staff helpful
 - d. Easy
- 4. Physical recovery
 - a. Easy
 - b. Short (4 weeks)
 - c. Physically active
 - d. Presence of support
- 5. Expectations
 - a. Realistic
 - b. Provided detailed, accurate information prior to surgery
- 6. Outcomes
 - a. Regret lack of breastfeeding information

Narrative Seven: Cathy

Cathy was planning on a vaginal delivery through out her entire pregnancy. Cathy reported a very easy pregnancy, gained very little weight, and was able to exercise four times a week. Then at a routine prenatal visit Cathy was found to have high blood pressure. "I went to my appointment and while the nurse was taking my blood pressure I realized it was 140/100 (I am a RN in the ER) and normally it is 100/50, so I was a little concerned." The nurses and

doctor took her blood pressure several more times. They even had Cathy rest with the lights off to see if her blood pressure would come down, but nothing helped. Cathy recalled, “I felt fine, but now I am even more anxious.” The doctor offered Cathy the option of going home for the weekend on bed rest with blood pressure medication and a 24-hour urine collection kit or having a cesarean birth that day. Cathy explained, “I was not eligible to be induced that day since the baby was still high and my cervix was not dilated.” Cathy had some prior knowledge of a cesarean because her Mom had had one with her and because most of her friends had had cesarean births. Cathy remembered the doctor explained that he was not on call that weekend and if something went wrong he would not be the one to see her. Cathy recalled, “This was a major deciding factor in my decision to go ahead with a cesarean instead of going home and possibly being induced the following week.” Cathy was supposed to meet the doctor at the hospital in an hour. Cathy shared, “I was scared out of my mind!”

Once Cathy arrived at the hospital she was started on an intravenous Magnesium Sulfate drip to prevent seizures. Cathy described, “The mag sulfate drip made me feel beyond terrible.” Cathy was very anxious during the surgery despite having her husband with her. Cathy experienced a variety of fears.

I was worried about the baby and about bleeding out. The magnesium made me paranoid about everything. I thought my blood pressure was too high, and then too low, I could have a stroke or cardiac arrest on the table. I was scared the baby would be still born.

Cathy felt a little better after the baby was born, but continued to worry. Cathy was so anxious that the anesthesiologist finally gave her medication to make her sleep while the doctors finished the surgery.

After the surgery Cathy remembered, “I woke up very groggy and still feeling like crap from the mag sulfate drip.” The situation was made worse for Cathy by the fact that the baby had to go to the neonatal intensive care unit (NICU). Cathy recounted,

It was horrible. I was unable to breastfeed and she got a bottle first, I was unable to see her for 24 hours! I was jealous of my husband who was able to go in and out of the NICU and hold her, change her diaper and feed her her bottle.

Fortunately, things improved for Cathy once her magnesium was turned off because she was able to see her daughter. However, Cathy’s anxiety continued, “My daughter had oxygen, a nasogastric tube, and an IV so that was scary. I kept having thoughts that she would stop breathing in my arms.” Although having her daughter in the NICU was scary Cathy explained, “Everyone was reassuring and helpful.” Cathy was able to start breastfeeding once she was able to go to the NICU. Cathy received much support from the lactation consultant and the NICU nurses. Cathy remembered, “I must say the nurses were great, especially the NICU nurses. They reassured us everyday that Kerri would be ok and taught us valuable information that all new parents need.”

After just 5 days, Kerri could be discharged home. Cathy recalled, “At first I was very anxious to take Kerri home, not knowing what I was doing.” Cathy’s husband was home from work the first two weeks. Cathy also had additional help from her mother. Cathy shared, “Luckily I have a lot of support from family, especially my Mom who came over every day.”

Physically Cathy reported healing very well. “I was up and walking as soon as my magnesium was discontinued.” Emotionally Cathy remembered feeling depressed and anxious for about two weeks. Fourteen weeks after her surgery Cathy expressed, “My baby is healthy as can be. Life is good.” As for her feelings about the surgery, “I am not sure it was 100%

necessary in my case, but unfortunately I know how the system works. I miss the experience of not going into labor but luckily I have the greatest gift, my beautiful daughter.”

The themes for Cathy included:

1. Decision
 - a. Ability to have own doctor
 - b. Influences of birth stories
2. Emotions of birth
 - a. Fear
 - b. Anxiety
 - c. Jealous
3. Missing out on vaginal experience
4. Acceptance of birth method
 - a. Question if necessary
 - b. Healthy baby
5. Emotional recovery
 - a. Anxiety
 - b. Presence of support
 - c. Depression
6. Physical recovery
 - a. Easy

Narrative Eight: Michelle

Michelle was planning on having a vaginal delivery even when her doctor began discussing a cesarean. Michelle’s doctor thought she was going to have a baby over 10 pounds

and as she explained, “It was his practice to always do a cesarean if the baby is over 10 pounds.” Michelle was shocked that he mentioned a cesarean because she didn’t really feel the baby was that big. Initially Michelle thought, “Ok he’s saying this now but she’s not really going to be that big and I’ll end up having a vaginal birth.” Michelle explained, “I wasn’t really looking forward to it [a cesarean birth]. I wanted the normal delivery.”

As the weeks went by and the baby wasn’t dropping Michelle began to think a cesarean was more likely, so she began talking to people. Michelle recounted, “I wanted to be mentally prepared.” Michelle’s friends related stories of positive cesarean births and long horrible labors. At the next routine ultrasound Michelle’s amniotic fluid levels were found to be low and she was sent to the doctor’s office. Michelle remembered, “He was concerned about having a big baby and that the fluid was really low so he wanted to take the baby the same day to make sure everything would be safe.” There was not much time for Michelle to think about having a cesarean birth, but while at the office she recalled, “I shed a few tears just because it all kind of overcame me in terms of; this is really happening, we are having a baby, there is no one more day and I am having surgery.”

Michelle and her husband got to the hospital and things did not start very good. Michelle reminisced about how she was stuck seven times and then needed the anesthesiologist to put in the IV. She shared, “I thought ok, it’s got to get better then this.” Michelle had previously had other surgeries so she knew a little about anesthesia, but this time was different because she was having a spinal instead of general anesthesia. Michelle explained,

It was weird this time because you were awake and actually heard and smelled everything. Like the flesh burning, so that was kind of freaky to be like, what’s that smell, oh wait that’s my skin burning when they are cutting me open.

Michelle described trying to stay calm, “I was focusing on just getting the baby out and having a healthy baby.” It wasn’t long before the baby was born. Michelle remembered being the first one to touch her daughter, “I touched her bloody foot with my hand and it was amazing even before he gave her to the nurses to get clean. That was a pretty special moment.” As Michelle had thought the baby was not that big and was born weighing only 7 pounds 14 ounces.

Physically, Michelle felt her recovery went well. During her pregnancy Michelle expected her recovery would go well, “It’s like mind over matter, how your recovery will be is how you want it to be. If you want to get better quicker you will.” So with that mindset Michelle was out of bed and moving the next morning. Michelle also explained, “I think being in the best shape possible and exercising during my pregnancy helped me. I was able to come home and take care of her, and I go up and down stairs every day.” Michelle described how having her husband home with her the first two weeks was helpful. Michelle reported having the most difficulty with breastfeeding. She shared, “Breastfeeding was definitely by far more challenging then the cesarean and recovery itself. The breastfeeding was pretty intense especially when you do not know what you are doing.”

Michelle’s emotional recovery was a little more difficult then the physical recovery. Michelle explained, “Emotionally I was so tired when I came home. I felt like I was being a machine. You are just doing, and then you sleep and then you do. I didn’t really have time to think about how I felt.” Michelle remembered it hit her a couple of weeks after she was home and then she broke down. Her difficulties breastfeeding added to her emotional distress. “That was a big emotional thing for me because there was a couple of times that I wanted to give up and I didn’t; I kept getting through it. That was probably were the emotions hit me the most.” Happily Michelle shared she is now doing well and the breastfeeding is pain free.

In the end the actual procedure and recovery went better than Michelle anticipated, “Overall my experience was better than I thought it would be.” Michelle reported many of her friends had babies during the same year and they are now closer as they share their experience of raising their children. Michelle also sees her family a lot more since the birth of her daughter. “It’s so nice to have everybody around and so in love with her.”

The themes for Michelle included:

1. Decision
 - a. Influence of birth stories
 - b. Safer for the baby
 - c. Medical issue but c/s not required
2. Emotional roller coaster of birth
 - a. Shock
 - b. Denial
 - c. Emotional
 - d. Anxious
 - e. Keeping calm
 - f. Amazing
3. Emotional recovery
 - a. Harder
 - b. Tired
 - c. Breastfeeding difficulties
4. Physical recovery
 - a. Easy

- b. Positive attitude
 - c. Physically fit
 - d. Active
 - e. Presence of support
5. Expectations
- a. Better than expected
 - b. Realistic
6. Outcomes
- a. Improved relationships

Narrative Nine: Debbie

Debbie knew before she even got pregnant that she wanted to have a cesarean birth. Debbie had a history of high blood pressure before her pregnancy, so because of this she was concerned she would need an emergency cesarean. Debbie shared, “I was nervous that I would not have a good experience having it be an emergency or having me be in distress or the baby be in distress.” Debbie felt knowledgeable about cesarean births because most of the people she knew had one. Debbie felt confident in her decision as she recounted, “Pretty much all the cesarean stories were all positive and all the vaginal deliveries were terrible.”

Debbie was not afraid to advocate for herself. She explained, “My first group of doctors was not receptive to planning an elective cesarean. They discounted my blood pressure issues all together.” So at five months pregnant Debbie switched to a different obstetrical group. Debbie described how pleased she was with her new group, “The doctors took me very serious when I voiced my concerns about the c-section, and they were very receptive. They wanted my

birthing experience to be the best it could be.” Debbie felt, “A cesarean is a very controlled situation and there was nothing to get stressed out about.”

Debbie remembered how friends would try to discourage her from having a cesarean birth. Some people expressed their concerns, “I wish you wouldn’t have a cesarean, it’s so dangerous” and “Oh my goodness, you are going to be out of commission. It’s going to be painful. I am worried.” Other people would try to talk Debbie out of having a cesarean, “Oh, don’t you want the experience of a vaginal delivery?” Debbie would respond, “Nope, I am all set with that.” Debbie explained, “I am a planner. I like to know when things are going to happen so in my mind I was good with my decision.” Debbie further explained, “I wanted it to be a good experience for me, if they had a good experience and a vaginal delivery worked for them then that was great, but this was my choice and I didn’t want it any differently.” It didn’t bother Debbie what people had to say, she was confident in her decision.

Debbie’s planned cesarean allowed her family to arrive in advance. Debbie recounted, “We had a kind of big celebration dinner, my last dinner. Everyone got to be there and we had a really good time.” The morning of the surgery Debbie remembered, “I was really tired and uncomfortable so I was ready to have the baby. I was totally calm.” Then Debbie’s surgery was delayed due to another emergency, so now she began to get nervous. “I had more time to stew and think about all these possible things and you are uncomfortable. I had never had surgery. I had never been in the hospital.” Debbie began to doubt her decision; “I’m thinking why did I do this to myself, this is crazy I am electing to do this.” Debbie remembered, “I began to clam up and get nervous.”

Fortunately Debbie did not have to wait long. Once she was in the operating room her nerves began to calm. Debbie explained, “They were awesome with me; any questions I could

have had they were answering before I could even think of it.” Debbie went on to say, “You know they put you at ease because they do it every single day and nothing is going to go wrong.” Debbie remembered how fast the surgery was, “It was crazy from the time going in it was so fast and then you are like, Oh my God she’s hear!” Debbie recounted how she was able to do skin to skin in the operating room. “After the baby was born they brought her right to me and put her on my chest which was an amazing surreal thing.” Debbie shared how the baby never left her side. “It was a really great experience for me. The surgery was better then I expected.”

Debbie’s physical recovery went equally as well. “I was a little bit sore, but I didn’t have any issues with pain.” Debbie reported, “I didn’t feel like there was anything I couldn’t do because of the cesarean.” Debbie felt her quick recovery was due to her physical fitness. She had always been athletic and exercised all the way through her pregnancy until she was put on bed rest due to her blood pressure. “I think the fact that I exercised help me recover so fast from my section.” Debbie also had a lot of help when she returned home. Her husband was home the first two weeks and she was living with her mother the first six weeks. “I had so much help that if I wanted to sleep there was someone who was happy to hold the baby or feed her.” Debbie commented, “I felt like I got back to my old self really quick.”

Debbie’s emotional recovery was also positive. Debbie explained, “I am head over heels in love and I still am. I am surprised I am so crazy about her.” Debbie reflected, “I knew that I would feel that way but not as extreme as I do. No one can explain it to you, there are no words and no one can explain the feeling until you have your own. “Besides being so enamored with her baby Debbie also attributed her quick recovery to her support from her husband and family and “It was summer and I was able to get out and go for walks and visit people. I was not

cooped up anywhere.” Debbie felt she now has a better relationship with her in-laws, “There is more of a reason to go and visit and talk.” Debbie also felt her relationship with her husband had improved, “I think because I see a different side of him, maybe a softer side.” Debbie shared, “I think one person can change a perspective and everybody was excellent. They really make the difference. It was a totally wonderful experience!”

The themes for Debbie included:

1. Decision
 - a. Always wanted cesarean
 - b. Influence of birth stories
 - c. Need for control
 - d. Empowered
 - e. Advocated for self
 - f. Medical issue but c/s not required
2. Stigma of cesarean
 - a. People try to change mind
3. Acceptance of birth method
 - a. Wanted positive experience
 - b. No desire for vaginal experience
4. Emotional roller coaster of birth
 - a. Ready to go
 - b. Fear of surgery
 - c. Doubt decision
 - d. Supportive staff helpful

- e. Calm
 - f. Amazing
 - g. Easy
5. Emotional recovery
- a. Easy
 - b. Presence of support
6. Physical recovery
- a. Easy
 - b. Short
 - c. Physically fit
 - d. Active
 - e. Presence of support
7. Expectations
- a. Better than expected
 - b. Realistic
 - c. Importance of health care providers
8. Outcomes
- a. Improved relationships

Narrative Ten: Emily

Emily never thought her birth story would include a cesarean delivery. “I always thought I would deliver vaginally, but then once I found out I was pregnant with twins everything changed and pretty much from the beginning I was going to have a cesarean.” Despite being in the hospital for over a month before the twins were born, Emily did not feel she had much

knowledge of a cesarean birth. She did not know anyone who had a cesarean birth that she could talk to. She remembered, “I didn’t really know what I was getting into.” One of the twins had low amniotic fluid and so Emily was hospitalized on bed rest and was monitored every day. Emily was able to work while in the hospital which provided some distraction, but the daily testing was very anxiety provoking. Emily remembered, “You are laying there and it is a test and you are watching the needles go up and down and hoping for it to stay consistent.” Emily didn’t realize just how anxious she was until the day of her surgery. “I didn’t really understand the trauma the testing was putting me under until the day I went to have the kids.”

The day of the surgery Emily felt the doctors had given her very little information about the surgery. She remembered being told routine information about the surgery and anesthesia. Emily explained, “So the rudimentary stuff that they tell a patient is what I was told. We didn’t really know what to ask... I wasn’t prepared at all.” Once in the operating room the doctors explained what would happen, Emily shared, “They kind of walk through the process but I was in a complete fog at that point.” Emily described the whole process as strange and awkward. During the spinal Emily recalled, “I remember hugging the nurse in front of me trying to wrap my arms around her to be in the correct position and that was awkward because I didn’t even know the person, I hadn’t seen her before.” Once the spinal was in Emily began to panic, “Oh my God I could be paralyzed, oh God well wait a minute I am paralyzed now I can’t feel a dang thing.” Emily felt her husband was equally scared, “I think he wasn’t prepared for it either because he never held my hand.” Emily’s feeling of loneliness added to her fear, “If I had just someone be able to hold my hand I think I would have felt better but I didn’t even have that.” Emily went on to share, “I actually hyperventilated through the entire delivery of my children and panicked the entire time because of poor information or lack there of.”

Emily's negative emotions did not subside as the surgery progressed. She described, "The whole time I am looking at my husband's eyes and he is kind of staring and there is not anything on his face, which is very uncommon for him, so it's just like wait and see at that point." Emily's daughter was born first and came out healthy and crying. Next came Emily's son and no noise. "Then my son was delivered and I didn't hear anything. He had swallowed some fluid and was kind of escorted right out of the room." Emily's panic escalated.

You are expecting to hear something and you didn't hear it. I just kept looking at my husband asking, "Where is the other one?" I remember the doctor saying he swallowed fluid and I really didn't understand what that meant, was he breathing? Was he not? What was going on?

Emily's son was eventually brought back into the room and was fine, but Emily described additional disappointment. "My husband didn't hold either of them and I wasn't able to even put them on my chest, they were just whisked away." Emily's fear of her surgery continued even after the operation was over, "I was really scared to look at the sutures. I tried not to look at it. I tried not to understand what just happened."

After the delivery, Emily's son was able to go to the regular nursery, but her daughter needed to go to the NICU for several days. Emily struggled as she tried to breastfeed her son, pump breast milk for her daughter, and try to get to the NICU for visits. She recounted, "It was tough having one baby with me and the other one in the NICU. It felt like half of me was in a distant orb." Emily remembered feeling sick and being heavily medicated, but needing to see her daughter. "I couldn't hold myself up trying to see her, but it was important; we didn't know if she was going to make it... so I wanted to be there with her as much as I could." Emily was finally able to experience some joy when her daughter was transferred out of the NICU. "When I

had them upstairs in the same room with me that was the best thing in the world because they were right there sleeping side by side each other and I could watch them.”

Although Emily was happy to have her babies with her, the pain made it difficult for her to take care of the babies and herself. A feeling of lack of support further complicated Emily’s difficulties caring for her twins. Emily was trying to breastfeed her twins but her milk had not come in yet and she was worried about the health of her daughter, so she gave her a bottle. “The lactation Nazi came in and was surprised that I was feeding my daughter a bottle.” Having twins compounded Emily’s frustration with breastfeeding. She explained, “The other part of it is having twins, how do you do that? And how do you hold them? And how do you manage the stress of it if they don’t want to latch on to you?” Emily felt like she could have used more guidance in the hospital and especially when she got home.

Emily continued to try to breastfeed the twins for the first two months she was home, but eventually she gave up. “I was pumping and trying to get them to breastfeed. I was trying to do it all but with very little information and or help. So I gave up... I didn’t feel like I was being a very good mother.” Although Emily struggled with breastfeeding she described how helpful her husband was with everything else. “My husband was a big help. He jumped right in and did whatever needed to be done. If it weren’t for him I never would have survived having twins.” Emily described her husband’s approach, “What are you going to do? God put it in front of you, you gotta handle it and so we did.” Emily went on to explain “If you don’t have support, you don’t have parents, or in-laws around then you have to rely on each other and through that experience with the twins it certainly made us stronger as a couple.”

Emily’s husband went back to work after a couple of weeks and Emily was left alone to care for the twins. “It sucked when he went back to work and I was by myself, that was just no

fun.” Emily settled into a routine and reported the time went by really fast. Emily only had a few additional weeks home before she returned to work only 6 weeks after delivery. Emily was able to get a nanny to care for the babies while she was at work, but even that was a stressor for Emily. “It was so difficult to manage the nanny, try to get the right person to take care of them and understand what to do with two babies when you didn’t even understand what to do with them yourself.” Emily discussed how busy she was and how fast time went by,

I felt like I don’t remember the first two years of their life. It was such a blur; it was just day-by-day, hour-by-hour, and minute-by-minute at the end of the day trying to get everything adjusted.

Emily never described herself as depressed, but she continues to deal with issues of anxiety. “I think my anxiety level ever since I had the kids just went up a notch. I think I was more aware of anxiety then I ever was in my life because I never had that issue.” Emily explained how she tried to exercise to relieve stress and anxiety. “When I was on maternity leave I would go out for walks with the kids in the stroller.” Emily recognized the importance of taking care of herself. “Doing something for me was always important ... with the twins I was not physically active. I couldn’t do anything.”

As Emily reflected back on the whole experience she stated, “I think it was worse then I expected.” Emily had known her doctor and had specifically asked her to come in for her delivery, but yet she felt disappointed in her care. “When it came to the actual surgery what I was missing was the actual common ground that a woman would give you who had been through it before.” Emily was looking for some advice and information on aspects other than the specifics of the surgery. Emily shared, “I think doctors do this day in and day out and they kind of forget.” Emily stated it was probably a year before she felt like she was back to her pre-pregnant self.

Emily is currently pregnant with one baby. She reports feeling less stressed, “Now being pregnant, it has actually seemed more fun.”

The themes for Emily include:

1. Decision
 - a. No option due to high risk pregnancy
 - b. Medical need
2. Emotions of birth
 - a. Anxiety
 - b. Panic
 - c. Unprepared
 - d. In a fog
 - e. Awkward
 - f. Fear of anesthesia and health of babies
 - g. Loneliness
 - h. Denial
3. Emotional recovery
 - a. Trauma of pregnancy
 - b. Struggle
 - c. Separation of babies
 - d. Frustration
 - e. Lack of support breastfeeding
 - f. Failure as a mother
 - g. Stressful

4. Physical recovery

- a. Separation of babies
- b. Painful
- c. Difficult to care for babies
- d. Breastfeeding difficulties
- e. Presence of support
- f. Active
- g. Long (1yr)

5. Expectations

- a. Worse then expected
- b. Disappointed in care
- c. Lack of emotional support from providers

6. Outcomes

- a. Improved relationships

Narrative Eleven: Rachel

From the time Rachel was a teenager she knew if she wanted to have children she would need to have a cesarean birth. Rachel had been diagnosed with Crohn's disease at the age of 18 and had had multiple abdominal surgeries. Because of the multiple surgeries the obstetrician felt it was safer for Rachel not to go into labor. Rachel was hesitant to have another surgery. Rachel remembered,

They said they would be able to use the same scar I had from an earlier Crohn's surgery, but it is still having your abdominal muscles cut and all the healing; I

didn't want to go through all of that again but this is what I had to do to have a child so this is what I went through.

Rachel had a good pregnancy without any flare-ups of her Crohn's disease. Her surgery was scheduled a week prior to her due date. Since Rachel had previously had abdominal surgery she knew what to expect. Rachel explained, "Since I wasn't going to go into labor I really didn't need childbirth classes, but I kind of felt like I missed out on something by not taking part in that". Although Rachel had experienced other surgeries she had never had a spinal before. She recounted, "That for me was the scariest because I knew if they were off just a little bit I could be paralyzed and that frightened me." Rachel's fear was further intensified when she entered the operating room. "To make it worse there is no one in the room with you except the nurses and the anesthesiologists, but they are all strangers." Rachel remembered her husband coming into the operating room and being very nervous, "I think it's the fear of the unknown." It wasn't long after that Rachel's daughter was born and she felt a sense of happiness. Rachel explained how the tension was broken when they first saw their daughter, "She came out butt first and looked like a flip phone because she just kept folding in half." Both Rachel and her husband were able to hold the baby while the doctors finished the surgery.

Physically Rachel recovered quickly. For the first few weeks Rachel's husband and family were at home with her to help. Rachel felt her recovery from her cesarean was much easier than her previous surgeries. "Compared to what I had been through, there was no comparison; I really think the first surgery was barbaric." Rachel also felt her recovery from her cesarean was easier because prior to the Crohn's surgery she had been so sick. Rachel reported feeling fully recovered from her cesarean birth within 12 weeks. Emotionally Rachel did not

report any problems. Rachel explained, “when I was growing up I always loved children, I would play with them and take care of them; so when it came time to have my own I was ready.”

The themes for Rachel include:

1. Decision
 - a. No option due to medical history
 - b. Medical need
2. Missing out on vaginal birth
3. Acceptance of birth method
 - a. What had to be done to have a child
4. Emotional roller coaster of birth
 - a. Fear- spinal/paralysis
 - b. Loneliness
 - c. Happiness
5. Emotional recovery
 - a. Easy
 - b. Presence of support
6. Physical recovery
 - a. Easy
 - b. Short (12 weeks)
 - c. Compared with prior surgeries
 - d. Presence of support
7. Expectations
 - a. Better then expected

b. Realistic

A Metastory of First Time Mothers' Experiences of a Planned Cesarean Birth

Seven overarching themes exposed the story of first time mothers' experiences of a planned cesarean birth. Analysis of the individual narratives as a whole allowed for the emergence of thematic categories. Within the theoretical framework of Roy's Adaptation Model a metastory was fashioned from the fusion of themes. The metastory embodies the experience of first time mothers who have a planned cesarean birth. The seven overarching themes include: The Decision, Not Much of a Choice; Acceptance of Birth Method; Emotional Roller Coaster of Birth; Physical Recovery, Feeling Like Myself; Emotional Recovery, A Kaleidoscope of Feelings; Expectations, A Picture in my Mind; and Outcomes, Ties That Bind (Table 3).

Overarching Theme 1: The Decision, Not Much of a Choice

All the participants began their story with how they came to have a planned cesarean, yet it is here where the similarities end. For some of these mothers the decision was made prior to conception, others came to the decision gradually, and still others decided the same day as their surgery. Six of the participants had medical conditions requiring a cesarean birth such as twins, breech position, and prior uterine and intestinal surgery. Two of the participants had always wanted a cesarean birth due to anxiety over delivering vaginally. However, these women both described having medical conditions that they felt necessitated a cesarean birth, and thus was the reason they requested a cesarean birth. Initially both participants had doctors who were reluctant to schedule a cesarean birth early in the pregnancy. So these women advocated for themselves and found new doctors who would perform the surgery.

The remaining three participants were encouraged by their physician to have a cesarean delivery. One participant remembered, "Upon my first examination I was diagnosed with a

bicornuate uterus. I remember the conversation being immediately diverted to the complications that could arise during delivery.” A second participant explained, “My doctor started having a conversation with me at about 37 weeks. He thought I was measuring big and it is his practice that if the baby is over 10 pounds he always does a cesarean.” Another participant remembered, “He offered me the option of going home and being induced next week or having a cesarean that day, but he explained that he was not on call that weekend and if something happened he would not be the one to see me.”

Regardless of why the decision was made to have a planned cesarean birth all of the participants felt there were few birth options to consider. Two of the participants wanted a cesarean birth. For these women there were no decision to make, their mind was all ready made up. The remaining nine women did not want to have a cesarean birth, but they felt they had no choice. The feeling of not having any option is characterized as “the decision, not much of a choice”. This theme is further subdivided into two subthemes: Influence of birth stories and Safety of the Baby.

Subtheme 1. Influence of Birth Stories

Five of the participants shared how the birth stories of other women influenced their decision to have a cesarean birth. When given an option of attempting a vaginal delivery or scheduling a cesarean birth many of the participants turned to family and friends for advice. What they heard were stories of short, easy cesarean births and long, horrible, painful labors. One participant shared, “My cousin had a baby while I was three months pregnant and had a horrible 23 hour natural birth. When I arrived at the hospital she gave me all the horrible details which made me even more certain that a c-section was the way to go.” Another participant recounted, “One of my friends was induced and sent home twice and then couldn’t get into

labor.” Yet another participant was told by a friend, “I am so glad you are having a cesarean because I still hurt from my vaginal delivery a year ago and my c-section was so easy and amazing. Once it is over you don’t feel it.” None of the participants remembered hearing stories of positive vaginal births or women who had suffered surgical complications or lengthy recoveries. These negative depictions of vaginal deliveries helped the participants to feel comfortable with the decision to have a cesarean birth.

Subtheme 2. Safety of the Baby

For four of the participants the safety of the baby was another factor that led to a feeling of not having a choice. One participant explained, “I wanted desperately to deliver vaginally, but I opted for the planned cesarean, as in the end the risk to the baby was much less... I wasn’t for a second going to put my baby in potential harm.” Both of the women who had babies in the breech position were offered the option of a version (manually rotating the baby externally), but instead opted for a cesarean birth. One participant remembered, “We did not want to assume those risks for a procedure that may or may not change the outcome of having surgery.” Similar thoughts were expressed by another participant, “It’s 2014, she’s breech and this is the safest way to bring her into this world, let’s just move forward with it.” Still another mother discussed, “the doctor wanted to take the baby out to make sure everything would be safe.” All of these women were willing to forego their own desires for a vaginal birth in order to provide what they felt was the safer alternative for their baby.

Overarching Theme 2: Acceptance of Birth Method

Only two of the participants desired a cesarean birth prior to becoming pregnant, the remaining women all had envisioned vaginal births. Thus, the remaining nine women needed to come to terms with an alternative birthing method. People encouraging vaginal births sometimes

hindered acceptance. One participant explained, “People would ask me if I was still thinking about having a natural birth and that it was good for a baby to go through the natural delivery process.” Another participant described a similar experience; “People did try to talk me out of it. They said don’t you want the experience of a vaginal delivery.”

For other women their acceptance was plagued by their own ideas of what is the best method of delivery. One participant shared,

I didn’t want to have a cesarean birth... honestly I didn’t feel that it was normal. I believed to some degree my experience would be inadequate to those whom delivered vaginally. I had a twisted interpretation that they had to work harder and therefore deserved the prize more- the reality was I was just going to lay there.

Another participant discussed how she also struggled with her feelings about cesarean birth,

I was sad not to have that womanly experience. Although I had seen the pain that women went through in natural labor I still wanted to see what it was like and do my best to fulfill a natural approach to childbirth.

Participants also described being plagued by the notion that vaginal births are “normal”.

Of the nine women who wanted vaginal deliveries, seven of these women discussed how they came to accept having a cesarean birth. This process of accepting a cesarean birth led to the emergence of theme two. This theme is further subdivided into two subthemes: Healthy Baby, and Faith and Support.

Subtheme 1. Healthy Baby

Six of the participants discussed the idea that it was easier to accept having a cesarean birth because they thought it would lead to a healthy baby. One participant explained, “They [the participant’s parents and husband] just wanted to make sure that both babies were born without

any issues, as did I.” Another participant described, “I opted for the planned cesarean as in the end the risk to the baby was much less. I decided and scheduled on the spot because I wasn’t even for a second going to put my baby in potential harm.”

Subtheme 2. Faith and Support

For some of the participants their faith and support from others made having a cesarean birth acceptable. One participant explained, “When I told my parents that I had chosen to have a cesarean birth they supported my decision and did not try to sway me.” Another participant shared, “This is how she wants to come into this world, so we’ll go ahead with that.” Still another participant expressed both sentiments when she described “I think having a supportive partner, my husband, and faith in God that this was meant to be for some reason; it helped me to accept having a cesarean delivery more easily.”

Overarching Theme Three: Emotional Roller Coaster of Birth

Childbirth by nature is an emotional experience, as was evident by all the participants’ responses. One of the participants, who had a breech baby, described a strictly positive experience, “I felt calm going in for surgery.” She went on to explain, “I have to say once hearing the baby cry I was so happy.” Two of the other participants expressed only negative emotions related to the birth, both of these women had high-risk pregnancies. One woman shared, “I was very anxious. I was worried about the baby and about my bleeding out... I was scared the baby would be stillborn.” The participant continued to be anxious even after the baby was born and finally was put to sleep by the anesthesiologist.

Another woman was also troubled by anxiety and panic and described only negative emotions, “I actually hyperventilated through the entire delivery of my children and panicked the entire time.” The same participant went on to say, “They kind of walk through the process but I

was in a complete fog at that point.” The woman explained that her husband appeared to be in a fog as well, “I think he wasn’t prepared for it [the surgery] either because he never held my hand. If I just had someone be able to hold my hand I think I would have felt better but I didn’t even have that.”

The remaining eight women described a range of emotions that often fluctuated between positive and negative. This vacillation of emotions constituted theme three, emotional roller coaster of birth. This theme is further subdivided into six subthemes: Fear, Doubt, Denial, Calm, Joy and Relief.

Subtheme 1. Fear

For the remaining eight women whose emotions fluctuated, they all experienced negative emotions of fear. Three of the participants discussed being fearful of the surgery. One participant shared, “As I waited to go into the operating room, I remember my entire body shaking uncontrollably. I cried uncontrollably from being so scared of what was to happen.” Another participant also described an increasing sense of fear as she waited to go to surgery, “I had more time to stew and think about all these possible things and you are uncomfortable because of the IV and I had never had surgery; I had never even been in the hospital ever.”

For the other participants, their fear was more related to receiving anesthesia. The fear of paralysis was discussed by a participant, “I think once I knew I was getting a needle in my spine that was when it hit me. Oh my God I could be paralyzed. Oh my God well wait a minute I am paralyzed now I can’t feel a dang thing.” Even women who had had prior surgeries were fearful of the anesthesia. One woman stated, “I had had other surgeries and tests done but I had never had a spinal. That for me was the scariest because I knew if they were off just a little bit I could be paralyzed and that frightened me.” Another woman expressed the same sentiment,

I had had surgery before so I kind of knew about the anesthesia, but they did a spinal and I have had full anesthesia before. It was weird this time because you were awake and actually heard and smelled everything. Like the flesh burning so that was kind of freaky to be like what's that smell, oh wait that's my skin burning when they are cutting me open.

The fear of anesthesia was often compounded by the fact that the support person was not allowed in the operating room while the anesthesia was placed. One woman shared,

My husband and I didn't realize that we would be separated for a short time before the procedure would begin- and I remember my heart racing as I walked into the operating room. The fear grew when I walked in and saw all of the instruments on the table. I was petrified of the epidural and now my husband wasn't with me!

Another participant described a very similar experience, "I remember going into the holding station and waiting and having all kinds of anxiety; what if I become paralyzed... and just being flooded with all these fears." She went on to explain, "So then it came time and I started to get wheeled away and Amy was told that she was not able to be with me during the anesthesia and I was surprised by that because I really wanted her with me."

Since the support person was not allowed in the operating room during the placement of the anesthesia the woman needed to rely on the nursing staff for support and assistance with positioning. The participants described this situation as awkward and lonely, which led to increased fears. One participant summed up these thoughts as she described, "I remember hugging the nurse in front of me and trying to wrap my arms around her to be in the correct position and that was awkward because I didn't know the person, I hadn't seen her before."

Another woman explained, “To make it worse there is no one in the room with you except the nurses and the anesthesiologist, but they are strangers.” Fear, whatever the reason behind it, was the most largely displayed negative emotion among the women having a cesarean birth.

Subtheme 2. Doubt

The negative emotions were not just restricted to those women who did not want a cesarean birth. Even those women who wanted a cesarean birth expressed moments of self-doubt. One participant shared, “I was gung ho ready to do the c-section until I got on the table to do the spinal. They struggled to get the spinal in... I was about to change my mind and say forget this I can go home and wait it out.” The other participant, who also requested a cesarean birth, experienced doubts as well. She explained, “My scheduled time got held up because they had an emergency so I had more time to sit there and think. So I am thinking why did I do this to myself, this is crazy I am electing to do this.”

Subtheme 3. Denial

For some of the women who did not want to have a cesarean birth they dealt with their emotions through denial. One participant who had been hospitalized for a month prior to the delivery and knew she was having a cesarean birth never thought about having surgery. She explained, “ I just kind of realized the day of the c-section, that the kids had to come out of me and I panicked.” Another participant was told she would need a cesarean because the baby was big but the woman remembers thinking, “ok, he’s saying this now but she’s really not going to be that big and in the end I’ll end up having a vaginal birth.” One participant continued to deny her cesarean birth even after the surgery. She explained, “I was really scared to look at the sutures. I tried not to look at it. I tried not to understand what just happened.”

Subtheme 4. Calm

Some of the participants were able to overcome their fears and were calm going into surgery. One participant described, “I remember the calmness that entered my body ... I was about to become a Mom.” Another woman shared, “Once verifying that the baby was still breech I felt calm going in for surgery.” Another mother described a similar experience; “I was really tired and uncomfortable so I was ready to have the baby. So I was thinking, ok we are going to go in and have the baby. I was totally calm.”

During the surgery one participant was calmed by the professionalism of the operating room staff. She recounted, “ You know they put you at ease ... they make you feel comfortable ... it was like ok we do this every day and nothing is going to go wrong.” Another participant was able to calm herself as she explained, “You could see my face and I just had a big smile on my face the whole time because we were having a baby and that’s kind of what I was focusing on just getting the baby out and having a health baby.”

Subtheme 5. Joy

Seven of the women discussed how negative emotions turned positive upon the birth of the baby. Upon seeing her baby for the first time one mother shared, “I still remember feeling like I was floating in the air. No pain. Pure joy and excitement!” One participant explained, “It was very emotional to hear her cry for the first time and remains one of the most wonderful moments in my life.” The joy continued to increase as the participant was able to see her children, “Finally my fear was gone and a huge sense of relief and joy filled me.” Several women were even able to do skin to skin in the operating room. One woman described, “ After the baby was born they brought her right to me and put her on my chest which was an amazing surreal thing.” Another woman recounted, “The doctor really wanted me to be the first one to touch her, so I touched her bloody foot with my hand and it was amazing even before he gave

her to the nurses. It was a pretty special moment.” Still another participant remembered, “They brought her to me and I held her for a second on the table. That was one thing I told my husband I wanted and I was thrilled.”

Subtheme 6. Relief

While hearing the first cry or seeing the baby for the first time brought joy to some of the participants for others these moments evoked a sense of relief. One woman shared, “After hearing our sweet cry of our baby and getting the nod from the NICU staff present that she was ok we took a deep sigh of relief and cried ourselves.” Another participant described, “they showed me Kerri and I heard her screaming and I felt a little better after that.”

Overarching Theme Four: Physical Recovery, Feeling Like Myself

Cesarean birth is major abdominal surgery requiring extensive recovery. While all the women experienced a cesarean birth the duration and extent of recovery varied significantly between the participants. Some participants reported feeling fully recovered in as little as 2 weeks while others felt it took up to a year to return to normal. Eight of the participants described their recovery as easy. One participant described, “My recovery went pretty seamlessly once I got home.” Another participant explained, “I took it easy when I got home and stayed current with my pain meds and I really did very well. I recovered fairly quickly... from a physical standpoint I returned to normal living within two weeks.” Still another woman shared, “I didn’t feel like there was anything I couldn’t do because of the cesarean.”

The remaining three participants described long painful recoveries that took up to a year. One participant shared, “The pain made it hard to take care of the babies and even myself. It was really hard to move, to walk, to go to the bathroom, all of that.” Another woman described a similar experience,

So 6 weeks came and went and I was expecting to feel better and I didn't. I was still very, very weak, tired all the time, I couldn't lift things I wanted to, I had this belly which was still very huge. It took a full year before I really felt like I had regained my body back.

Two women, one of whom had requested a cesarean and one whom did not, described similar experiences related to a difficult recovery due to the pregnancy. One woman shared, "The recovery from the c-section was more recovery from the pregnancy for me." Another participant explained, "It felt like the pregnancy had snatched my body away and the operation did the same thing."

Whether or not the woman requested the cesarean birth did not impact the length of recovery. The need of all the women to discuss their physical recovery led to theme four: Physical Recovery, Feeling Like Myself. This theme was further subdivided into three subthemes: Presence of Support, Physically Active/fit, and Breastfeeding Difficulties.

Subtheme 1. Presence of Support

All of the participants except one discussed the positive impact of support on their physical recovery. Participants described how family and friends would help with household chores, baby advice, and infant care. One participant shared, "I did have help and thank God for it! My husband, Mom, Dad, and Mother-in-law were all readily available for guidance and care." Another participant explained, "Having people here when I first came home was helpful." Still another woman shared, "My husband was home with me for 3 weeks and that definitely allowed me to recuperate faster." One woman summed it up when she said, "I really enjoyed having everyone around. I think it made for a really smooth transition."

Subtheme 2. Physically Active/fit

Six of the women commented on the importance of exercise during pregnancy and being physically active after their surgery. One participant explained, “I worked out four or five times a week and I even worked out with a trainer twice a week with weights during my pregnancy. I tried to stay cardiovascular active because I read a lot that that helps.” Another participant had a similar experience, “I think being in the best shape possible and exercising during pregnancy helped me. I think I recovered pretty well.” Another woman described her experience, “We would go for walks and eventually it got easier and easier any my body became stronger. Eight weeks after the delivery I returned to the gym and my five day per week workouts.”

Subtheme 3. Breastfeeding Difficulties

For three of the participants their recovery was complicated by breastfeeding difficulties. One of the participants explained, “I think one of the more difficult tasks for me post-op was learning to breastfeed. I had difficulty positioning our daughter efficiently and comfortable in the first few weeks after delivery.” Another woman explained not only difficulty due to the cesarean but increased frustration due to lack of support. She shared,

It was very uncomfortable for me to have this incision, which was still healing, and nursing Emily who wasn’t nursing. I found that very frustrating. Emily just couldn’t latch on, I couldn’t hold her right, the incision was bothering me, and I just didn’t know what the hell I was doing.”

Overarching Theme Five: Emotional Recovery, A Kaleidoscope of Feelings

For most of the participants the emotional recovery was much more difficult then the physical recovery. While eight of the participants described their physical recovery as easy, only three of the participants described their emotional recovery as easy. One participant shared, “Sometimes it’s like mind over matter, how your recovery will be is how you want it to be. If

you want to get better quicker you will.” One of the women who had requested a cesarean birth described her emotional recovery as easy. She stated, “Emotionally things went well for me also. I felt like I just want to be with this baby all the time I was head over heels and I still am.”

Another woman who had requested a cesarean birth explained, “Emotionally I did not have any problems. When I was growing up I always loved children and would play with them so when it came time to have my own I was ready.”

The remaining participants described emotional difficulties. One woman explained,

Emotionally I was so tired when I came home. I felt like I was being a machine.

You are just doing and doing, and then you sleep and then you do.... so I feel like

I didn't really have time to think about emotions or how I felt. It was a couple of weeks later when it kind of hit me and I broke down.

Another woman expressed similar sentiments, “I felt like I don't remember the first two years of their life. It was such a blur; ... day by day, hour by hour, minute by minute at the end of the day trying to get everything adjusted.” Another participant shared, “I was flooded with all these emotions because the baby was just crying and crying... I remember sitting on the toilet and just rocking back and forth and just sobbing for no reason really.” The same woman went on to explain, “It was miserable because I was in pain, I was feeling very sad, and I was feeling inadequate.” While other women did not go into as much detail about their emotions, they discussed feeling “some depression” or “increased levels of anxiety”. The women's discussion of emotions after delivery led to the emergence of theme five: Emotional Recovery. This theme was further divided into two subthemes: Presence of Support and Breastfeeding Difficulties.

Subtheme 1. Presence of Support

Five of the participants discussed the presence of support and its impact on their emotional recovery. One participant explained, “I didn’t have postpartum depression at all and I feel like perhaps part of that is due to the fact that I did have someone there with me all day long helping me with everything from baths, to bottles to vacuuming and cooking.” Another woman shared, “ At first I was very anxious to take Kerri home, not knowing what I was doing. Luckily I have a lot of support from family, especially my mom who came over every day.” Another participant explained the importance of social interaction, “It was summer so I was able to get out and go for walks and visit people. I wasn’t cooped up anywhere. I felt like myself.”

Subtheme 2. Breastfeeding difficulties

The nature of a cesarean birth led to physical difficulties breastfeeding; these physical difficulties then further compounded the emotional recovery of the participants. One mother of twins expressed having difficulties and feeling frustrated. She remembered, “I was trying to do it all but with very little information and or help. So I gave up at about 8 weeks... I didn’t feel like I was being a very good mother.” Another participant explained, “I wasn’t sure if I was going to continue with the breastfeeding; that was a big emotional thing for me because there was a couple of times that I wanted to give up and I didn’t and I kept kind of getting through it. That was probably were the emotions hit me the most.”

Overarching Theme Six: Expectations, A Picture in my Mind

Seven of the participants discussed their expectations in relation to their experience. Two of the women had birthing experiences worse then they expected. One participant had prior abdominal surgery, so she compared her recovery from the cesarean birth to her earlier surgery and was disappointed. “So six weeks came and I was expecting to feel better and I didn’t.” Another woman stated, “Looking back on the experience I think it was worse then I expected.”

The remaining five women described their experience as having met or exceeded their expectations. One participant stated, “It was a totally wonderful experience.” Another woman shared, “Overall my experience was much better then what I thought it would be. The actual procedure and recovery went much better than I anticipated.” Another participant who had prior abdominal surgery explained, “Compared to what I had been through there was no comparison; I really think the first surgery was barbaric.” The participant explained how she felt better going into her cesarean birth. She also explained, “From the Crohn’s surgery I got relief from the pain, but from the cesarean I was getting a child.”

Subtheme 1. Importance of Prior Information

The participants discussed how having adequate information helped to create realistic scenarios and meet expectations. One woman shared, “So we [the doctor and the participant] went through everything from soup to nuts even from how long the procedure would take, when my parents could come in to recovery and things like that. So I felt very prepared for what was going to happen.” Another participant explained,

I did research on c-sections and spoke with others who had them. I was aware of the process and of the longer recovery time etc. I was not surprised at all when it actually happened and felt fully mentally prepared for it.

For other women the lack of information led to unmet expectations. One participant shared, “I wish I was better prepared for, they prepare you so much for how to breastfeed and troubleshooting and using the lactation consultant but they don’t prepare you for what if you can’t and that’s the only think I kind of wish they had done.”

Subtheme 2. Role of healthcare providers

The participants shared how the behaviors of the healthcare providers impacted their expectations. For some, the role of the provider led to expectations being met. One participant explained, “I had full faith in the operating staff at the hospital and high hopes for the surgery and recovery.” Another participant described, “My doctor was there and she was holding my hand.” Another participant discussed the role of the NICU nurses, “The nurses were great especially the NICU nurses, they reassured us everyday that Kerri would be ok and taught us valuable information that all new parents need. They made life so much better.” Another participant expressed similar thoughts about the staff, “The people that were there they make the experience. I think one person can change a perspective and everybody from a to z were all excellent and they really make the difference.” The staff positively impacted still another woman as she explained, “I think the people make the experience and everyone I had that day did their best to make me comfortable.” She went on to share, “They were just so professional and they had been doing it for so long and they were confident so I think that put me at ease.”

Other participants were disappointed by the performance of the healthcare providers. One participant explained the negative impact of experienced staff, “I think the doctors do this day in and day out and they kind of forget.” She went on to explain,

My doctor I had known, I had asked her to come do the delivery for me ... but when it came to the actual surgery what I was missing was the actual common ground that a woman would give you who had been through it before... like someone to tell me to remain calm.”

Another woman shared her disappointment when she discussed, “I think I expected a little more hands on from the nurses.”

Overarching Theme Seven: Outcomes, Ties That Bind

Seven of the participants discussed the end result of their cesarean birth. Regardless of whether the participant wanted a cesarean birth or not, all of the women were happy with the outcome. One participant shared, “I am very happy with the choice I made and with the aftermath of it.”

Subtheme 1. Improved Relationships

Some participants commented on the ability to make new friends because of the children. One participant explained, “I think in terms of my friends I am lucky because a lot of my friends had babies the same year, so we have gotten closer. We are always getting the babies together so that’s really great.” Other women discussed the changes in relationships with their in-laws. One participant described, “I think I have a better relationship with my in-laws now because of the baby. There is more of a reason to go and visit and talk.” Another participant also commented on her improved relationship with her in-laws, “This is a first grandbaby so everybody wants to be around her and see her all the time. So it’s nice to have everybody want to be around her and see her all the time.”

Other participants discussed changes in their relationships with their husbands. One woman explained, “I think my relationship with my husband is better than before because I see a different side of him, maybe a softer side.” Another participant also discussed her husband, “If you don’t have support, you don’t have parents, you don’t have in-laws around then you have to rely on each other and through that experience with the twins it certainly made us stronger as a couple.”

Subtheme 2. Happy to be a Mom

One participant explained, “Having been through that [a cesarean birth] there’s nothing in life I won’t be able to conquer! I’m so very glad to be a Mom.” Another woman shared, “Now I

am 14 weeks postpartum and my baby is healthy as can be. Life is good. I miss the experience of not going into labor, but luckily I have the greatest gift, my beautiful daughter.”

Summary

This chapter presented a depiction of the research participants in conjunction with a comprehensive summary of each narrative of the first time mothers’ experience of a planned cesarean birth. Each narrative was kept intact and analyzed as a whole resulting in the emergence of themes. The synthesis of themes from the individual narratives led to the creation of a metastory and seven overarching themes and subthemes that are representative of the entire sample.

Chapter five presents a discussion of the research findings. Final conclusions are drawn from the results. The relationship of the results to the theoretical framework is explained. The research is compared to the review of the literature. The implications for research, clinical practice, and education are contemplated.

Chapter Five: Discussion

Introduction

The metastory of First Time Mothers' Experiences of a Planned Cesarean Birth emerged from the seven overarching themes. These themes included: The Decision, Not Much of a Choice; Acceptance of Birth Method; Emotional Roller Coaster of Birth; Physical Recovery, Feeling Like Myself; Emotional Recovery, A Kaleidoscope of Feelings; Expectations, A Picture in My Mind; and Outcomes, Ties That Bind. Each narrative was analyzed as a whole and then synthesized with each other to reveal the overarching themes. The amalgamation of overarching themes resulted in the creation of the metastory.

Chapter five discusses the research findings within the context of the literature review and the theoretical framework of Roy's Adaptation Model. The relationship of the results to the theoretical framework is explained. The research is compared to the review of the literature. The implications for research, clinical practice, and education are contemplated. Finally, the strengths and limitations of the research are addressed.

Discussion

The Decision, Not Much of a Choice

Despite popular beliefs that the cesarean birth rate is increasing due to maternal request, the actual incidence of 1% is quite low (Declercq et al., 2013). This rate is supported in this study where only two of the participants requested a cesarean birth. Studies revealed similar low rates of maternal request (Kingdon et al. 2009; McCourt et al., 2007; Robson et al., 2009; Thompson, 2010). Although the women in this author's study who requested a cesarean birth were fearful of a delivering vaginally that was not the reason for their decision: they believed they had medical concerns that warranted a cesarean birth. Their physicians did not value these participants'

beliefs and so the women sought new practitioners who valued their fears and honored their requests. Weaver et al. (2007) reported similar experiences where the women believed they had a clinical indication, but were not supported by their physicians. Puia (2013a) also found that women who requested a cesarean did so because of their perceived need due to their medical history.

The remaining nine participants in this author's study all desired a vaginal birth, but felt compelled to have a cesarean birth due to the risks to the baby and/or physician recommendation. These results were supported by earlier studies, which revealed doctor recommendation was the most frequently reported reason for a primary cesarean (Fenwick et al., 2010; Puia, 2013a). Several studies revealed women viewed cesarean birth as a safer alternative to vaginal deliveries (Arthur & Payne, 2005; Kingdon et al., 2009; Weaver et al. 2007). In a study conducted by Keogh et al (2006) about the reasons for a planned cesarean, advice of the obstetrician and safety of the unborn child were the two main reasons. When faced with a decision to have a planned cesarean birth, the participants in this author's study frequently discussed safety of the baby as being a major contributing factor. The concern for one's baby was also commonly mentioned in the review of the literature (Arthur & Payne, 2005; Fenwick et al., 2010; Kingdon et al., 2009; Kornelsen et al., 2010; Robson et al, 2008; Weaver & Statham, 2005; Weaver et al., 2007; Wicklund et al., 2007). All of the participants in this author's study described feeling as if they had no safe alternatives, but to have a cesarean birth. The literature also addressed this illusion of choice in delivery method (Redshaw & Hockley, 2010; Wittmann-Price et al. 2011).

Although the participants in this author's study felt they had no choice some of the women were given the option of a vaginal birth. When faced with this decision the women frequently turned to friends and family for advice. Munro et al (2009) also found birth stories to

be very influential in the decision making process. The stories of friends and relatives conveyed negative vaginal birth experiences and positive cesarean stories. For many of the participants in this author's study the nature of the birth stories provided support to the women's decisions for a cesarean birth. The literature documents the strong influence of birth stories on decision-making as well as the negative portrayal of vaginal birth (Fenwick et al., 2010; Kornelsen et al., 2010; Munro et al. 2009; Puia, 2013a).

Acceptance of Birth Method

Nine of the women in this author's study had an unwanted cesarean birth. These women all desired a vaginal birth and thus needed to come to terms with an alternative birth method. Acceptance of a cesarean birth was often complicated by outsider's opinions. Participants reported continually being encouraged by others to attempt a vaginal birth because it was "better for the baby" or because it was "the natural way". Other participants were troubled by their personal beliefs about childbirth. Participants discussed cesarean births as "unnatural" and described, "missing out on a womanly experience". The literature also explored this notion (Arthur & Payne, 2005; Fenwick et al., 2003; Porter et al 2007; Puia, 2013b). Despite their beliefs in elective cesarean women felt guilty because they were not having a vaginal birth, which they perceived to be the normal method (Arthur & Payne, 2005). Women also were disappointed to not have the valuable life experience of a vaginal birth (Porter et al., 2007). Other women described feelings of failure because they were unable to delivery vaginally (Fenwick et al., 2003; Puia, 2013b).

The topic of women's ability to accept an alternative birth method is very limited in the literature. Redshaw and Hockley (2010) conducted the only study that addressed adjusting to a cesarean birth. Women reported support and information by healthcare providers and time to "get used to the idea" as factors in their acceptance. The emergence of a process to accept a cesarean birth was revealed in this author's study. Participants discussed the notion that having a healthy baby made it easier to acquiesce to a cesarean birth. Other participants relied on support from family or friends or their faith in God to provide themselves peace with their decision.

Roller Coaster of Birth

Participants in this study described experiencing a multitude of emotions during the birth, often fluctuating between negative and positive feelings. The majority of participants reported being fearful. The negative experiences of first time mothers having a planned cesarean in this study confirm prior research. Studies revealed that most women, regardless of whether the cesarean was planned or unplanned, experience fear and anxiety (Bluml et al., 2012; Fries, 2010; Porter et al., 2007; Puia, 2013b; Redshaw & Hockley, 2010). Bluml et al. (2012) found that a majority of women having a planned cesarean birth reported feeling anxious during the surgery. Participants in this author's study described their anxiety as, "hyperventilating throughout the entire delivery", "needing to be put to sleep because I was so anxious", and "shaking and crying uncontrollably from fear".

Many of the participants in this author's study specifically discussed their fear of having spinal anesthesia. This confirmed the findings from the literature review. Bluml et al. (2012) discuss women's concerns about anesthesia and possible complications. In a metasynthesis of women's experiences of a cesarean birth, women described fears of pain, the surgeries, as well as fear for her own life and that of her unborn child (Puia, 2013b). Despite the women in this

sample having either planned or unplanned cesarean births the fears reported were similar. Women having scheduled and emergency cesarean births also commonly reported anesthesia related fears (Porter et al., 2007). Fries, (2010) interviewed women having unplanned cesarean births also found that during the surgery women were fearful of anesthesia, pain, and the safety of their life and that of their baby.

The variance in emotions about a cesarean birth is a deficit in the literature. Redshaw and Hockley (2010) explored women's feeling at the time of birth. Emotions represented a continuum from "traumatized" to "extremely happy". This author's study also reflected the fluctuation in emotions and substantiated the literature. Upon the birth of the baby participants' negative emotions turned to positive feelings. Participants described feeling joy, excitement, and a sense of relief. The women went on to recount the birth as "amazing", "surreal", and "special".

Physical Recovery, Feeling Like Myself

The participants in this author's study all discussed their physical recovery. The women gauged their recovery not by the healing of the wound, but by how long it took to feel like themselves. The duration of the recovery time varied from 2 weeks up until a year and was not affected by whether the cesarean was requested or unwanted. Hobson et al., (2006) attributed quick recovery times with low levels of anxiety. A majority of participants in this author's study described easy recoveries with minimal pain, no physical restrictions and a quick return to normal living. These women attributed their easy recoveries to the presence of support by family and partners. The participants also conveyed the importance of exercise both prenatally and during recovery. Yet despite the presence of support some of the participants endured longer more painful recoveries. These women were surprised by the lengthy recovery time. Porter et al. (2007) corroborated such findings.

The literature rarely explored these quick recoveries, but rather more commonly addressed the difficulties (Kealy et al., 2010; Porter et al., 2007; Puia, 2013b). In a study by Kealy et al. (2010) women were interviewed about their recovery experience. The results revealed the women were unprepared for the physical imitations and many felt they were unable to provide good care to their infants because of the restrictions. Similar difficulties with mobility and caring for infant were reported in other studies (Porter et al., 2007; Puia, 2013b). In this author's study the participants frequently discussed breastfeeding as the biggest infant care issue. Participants recounted problems with positioning and pain, especially during the early days when trying to learn how to breastfeed.

Emotional Recovery, A Kaleidoscope of Feelings

Many of the participants in this author's study described their physical recovery as easy, yet only three participants reported their emotional recovery as easy. One of the women who requested a cesarean birth denied any emotional difficulties. She shared only feelings of love and infatuation with her newborn. Bluml et al. (2012) found similar results of low levels of depression and stress in women who had an elective cesarean.

Yet the majority of participants in this author's study shared emotional difficulties. One participant discussed feeling emotionless and "just going through the motions". Another woman described her first two years as a "blur". Other participants recounted feelings of depression and anxiety as well as periods of uncontrollable crying. The literature articulates similar negative emotions. Wilde-Larsson et al. (2011) found more negative feelings and perception of care were associated with those women having cesarean birth. This may be due to the sample containing both planned and emergent cesarean births. Stadlmayr et al. (2004) reported women who had an

elective cesarean experienced more negative emotions postpartum than women who delivered vaginally.

Expectations, A Picture in my Mind

Many women have preconceived ideas about how their childbirth will unfold. These preconceived notions may influence one's level of satisfaction. In a study conducted by Schindl et al. (2003) women who had requested a cesarean birth all reported very positive expectations and experiences of their births. In this author's study satisfying experiences were not restricted to only those women who requested a cesarean. Participants who had opted for a cesarean birth also reported being happy with their choice. Some participants even described birthing experiences that exceeded their expectations. The literature validates women's positive experiences of planned cesareans even if the women did not request the surgery. Bluml et al. (2102) found the majority (81.3%) of the women were satisfied with their birthing experience. Bloomquist et al. (2011) also found women who had a planned cesarean birth had higher levels of satisfaction and fulfillment and reported their birth to be less distressing and difficult than women planning a vaginal birth.

The literature suggests negative expectations can also impact women's experiences. Bryanton et al. (2008) found factors specific to planned cesarean births, which impacted perception of the experience, were degree of fear, satisfying feelings during the birth, and nursing support. Keogh et al. (2006) reported negative maternal prenatal expectations increase women's fear responses during surgery. The behaviors of healthcare providers and their impact on women's experiences were revealed in this author's study. Perceptions of the providers as experienced and caring led to positive experiences. One participant discussed how the experienced care calmed her fears and made for a pleasant birth. In a contrasting view, another

participant's perception of experienced providers led to a negative experience. The participant felt the providers were so experienced that they had lost their sense of compassion and her birth was just part of a routine.

In addition to provider behavior, levels of satisfaction may also be influenced by the amount of information supplied by healthcare providers. The adequacy of the information provided by healthcare providers was shown to impact women's level of satisfaction in several studies (Kolip and Buchter 2009; Puia, 2013a). Kolip and Buchter (2009) examined first-time mothers who had a planned cesarean birth. Over 75% of the women felt they had received adequate information from the physicians and midwives about the surgery. Puia (2013a) conducted a similar study of women who had a planned cesarean birth. The majority of the women (97%) remembered being provided with information on all aspects of the surgery. The women felt they had understood the information and that it was helpful. Overall, the women reported being satisfied with their decision for a cesarean birth (Puia, 2013a). Accurate and detailed information may help to decrease levels of anxiety. Hobson et al. (2006) found women with lower preoperative anxiety levels had higher satisfaction levels. In a similar study Bryanton et al. (2008) found that the degree of relaxation impacted the women's perception of the experience. The participants in this author's study discussed how being informed helped to create realistic expectations and satisfying experiences. Several of the participants who reported satisfying experiences described feeling very prepared for what was going to happen.

Information or lack of may affect a woman's level of anxiety. Several studies reported increased levels of anxiety due to unmet expectations and lack of information (Porter et al, 2007; Redshaw & Hockley 2010). Sometimes providing information was not enough. In a study conducted by Bluml (2012) only half the women felt adequately informed about the cesarean

procedure, despite receiving educational material and information from their providers. Similar results were found in this author's study when one participant explained how the providers informed her of the process but she was "in a fog" and couldn't comprehend what was being said. Another participant shared how she was told "the rudimentary stuff", but she was looking for more.

Other participants in this author's study reported having expectations unmet for different reasons. One participant compared her recovery from her cesarean birth to a prior surgery. The other participant reported being disappointed with the level of care because she expected more hands on from the nurses. Several studies in the literature also reported unsatisfying cesarean birth experiences (Chalmers et al. 2010; Fenwick et al. 2003). Fenwick et al. (2003) found a majority of the study participants (78%) reported their cesarean as traumatic and very disappointing. These results may be in part due to the sample containing both planned and unplanned cesarean births.

Lack of maternal infant contact also contributed to negative experiences (Chalmers et al. 2010; Fenwick et al. 2003; Porter et al, 2007). Chalmers et al. (2010) found women who had a cesarean birth were less satisfied with their birth experience and with the mother-infant contact than women who had vaginal births. Fenwick et al (2003) found separation from the infant during the surgery promoted negative feelings. Porter et al (2007) identified difficulty bonding with their baby as a distressing factor that led to a negative birth experience. In this author's study maternal infant interaction during the surgery led to positive experiences. Several participants shared how they were able to have their wishes met and were able to perform skin to skin in the operating room. Bryanton et al. (2008) also found that the ability to be with the infant during the birth impacted the experience.

Several participants in this author's study discussed how their partners were unprepared for the realities of a cesarean birth. A lack of preparation led to increased amounts of fear. The fears of their partners negatively impacted their experience. One participant in this author's study explained how her husband was so afraid he could not focus on his wife. He was unable to even hold her hand. Another participant also recognized her husband's fears as she described him as expressionless and staring in the distance. The husbands' fears prevented them from providing support to their wives. These negative emotions of the partner support Keogh et al. 's (2006) study, which found that fears of the birth partner might increase the negative maternal experience during and after the surgery. Bryanton et al., (2008) also found helpfulness of the partner to impact the woman's perception of the experience.

Outcomes, Ties That Bind

Conflicting results about the outcomes of planned cesarean births may be found in the literature. Some studies report negative experiences of disappointment and trauma (Fenwick et al., 2003; Fries, 2010; Puia, 2013b). These results may be due to the inclusion of emergent cesarean in these study populations. On the contrary, positive experiences for women having planned cesareans are demonstrated in the literature (Robson et al. 2008; Schindl et al. 2003; Wiklund et al. 2007).

Seven participants in this author's study discussed the outcomes of their cesarean birth, all of which were happy with the outcome. The two women in this author's study who requested a cesarean birth both reported satisfying birthing experiences. Whether or not the woman wanted a cesarean birth did not impact the end result as women who did not want a cesarean also reported positive outcomes. The literature supports these findings. Wiklund et al. (2007) also found 80% of the first time mothers who had requested a cesarean birth were satisfied with their

experience. Several studies (Kolip and Butcher, 2009; Puia, 2013a; Robson et al. 2008) found the majority of women were happy with their choice of birth method. Bloomquist et al. (2011) reported women who had a planned cesarean birth had higher levels of fulfillment than women planning a vaginal birth. Bluml et al. (2012) reported the majority of women were satisfied with their experience and only 12.5% of women felt the surgery was worse than expected.

In addition to the general outcome of the birth, participants also spoke of specific factors in their lives. Many of the participants discussed the positive impact of the birth of their child on relationships. Women reported bonding with friends and in-laws as they spend more time together with the baby. Women also shared feeling closer to their husbands as they work to care for their child. Women also reported seeing a more emotional side of their husbands. The participants also learned about themselves. One participant described her newfound inner strength after she endured a cesarean birth. Another participant discussed how she couldn't put into words how much she loves her baby and didn't expect that level of intensity. To these participants these added benefits of improved relationships made the cesarean birth worthwhile. The emotional benefits of a cesarean birth are not specifically discussed in the review of the literature.

Theoretical Framework

The purpose of research guided by Roy's Adaptation Model is to understand how people adapt to environmental stimuli. In the case of this study, the purpose was to describe first time mothers' perceptions of and physical, emotional, functional, and social responses to a planned cesarean birth. Thus RAM was a useful theoretical framework for this study. The individual narratives were interpreted based upon the RAM. The resulting seven themes and metastory reflected each of the four adaptive modes. The results of this study indicate the women had more

adaptive responses then ineffective. The literature supports this finding (Fawcett et al., 2011). Fawcett et al. (2011) found the modes of adaptation to be more strongly influenced by the cognator subsystem than the stimuli. While all the women in this author's study had planned cesareans, several of the women requested this method while others had wanted a vaginal birth, therefore the stimuli was slightly different among the study participants. The results of this study indicate the stimuli did not impact the adaptation as both groups of participants demonstrated adaptive responses. Instead the narratives revealed the modes of adaptation were impacted by the cognator subsystems. These results support one of the model's generic propositions that states, "the adequacy of the cognator and regulator processes affects adaptive responses" (Roy et al., 1999, p.547)

Recommendations for Nursing Practice

As with any birth an assessment of the woman's birth plan should be conducted. For those women who are planning a cesarean birth it should be determined what wishes the women had for a vaginal birth. When possible, healthcare providers should try to implement those desires into a cesarean birth. For example, providing skin to skin while still in the operating room. Those participants in this author's study who had increased maternal infant contact during the surgery reported increased levels of satisfaction. Nursing needs to work to improve institutional policies to decrease maternal infant separation during a cesarean birth.

Some of the women in this author's study reported feelings of failure, anger and grief related to "missing out" on a "normal birth" or a "womanly experience". First time mothers having a planned cesarean birth should be evaluated for any negative feelings related to their birth method and for their level of adaptation. Evaluations should occur both prenatally and after delivery as women's feelings may change after the birth of a healthy baby. When negative

feelings or ineffective adaptations are identified healthcare professionals need to provide support and education. The results in this author's study indicate increased support and information lead to more adaptive responses.

In addition to assessing birth plans the knowledge level of cesarean births should be determined. For those women who request a cesarean birth, the provider should evaluate the reasoning behind the decision. Some women may choose a cesarean because of medical reasons they believe require a cesarean. Other women may choose a cesarean because of fears of labor or a vaginal delivery. The provider should address any fears or concerns and accurate information should be provided. Ample opportunities for questions or concerns should be provided.

The results of this study indicate that those women who had adequate information prior to the birth were able to develop realistic expectations and attain a satisfying birthing experience. As the participants in this study indicated, many women turn to family and friends for information. The stories shared are often skewed towards long, painful complicated vaginal births and short easy cesarean births. Healthcare providers need to address any misconceptions and provide accurate, detailed information. Patient education should be provided at multiple time points to reinforce understanding. Adequate time should be allotted for questions and concerns. It is important to include the support person as well in these education sessions since increased partner fear led to decreased satisfaction for the woman. Healthcare providers need to address the educational deficits and prepare the support person as well as the mother. In addition to education sessions nursing should work to develop a peer support group, allowing first time mothers to speak with other women who had their first child by planned cesarean. This could provide the women with information from a patient perspective instead of the healthcare providers' viewpoint.

Many of the women in this author's study discussed difficulties with physical and emotional recovery due to issues with breastfeeding. Participants reported problems with positioning due to incisional pain and decreased mobility. Efforts need to be made by nurses to provide additional breastfeeding education specific to those women who had a cesarean birth. Increased follow-up with breastfeeding mothers should occur in the hospital and after discharge.

Recommendations for Nursing Education

In addition to patient education healthcare providers should be educated as well. Providers need to be educated to address emotions related to having an unwanted planned cesarean birth. For many healthcare providers the method of delivery is insignificant, the outcome of a healthy baby and a healthy mom is the only factor that matters. While the outcome is certainly important to the women, they also struggle with not having a vaginal birth. Opportunities should be made to assess the women's level of adaptation and when need be provide additional support.

It is important to recognize that just because a cesarean is planned does not mean the birth will automatically be a satisfying experience for the women. The results of this author's study indicate that the behaviors of healthcare providers have a strong impact on the women's expectations. Participants expected not only knowledge and expertise, but also caring and compassion. Helpful behaviors that participants discussed included small actions like holding a hand or brief conversations to provide distraction and reduce fears.

Several participants in this study discussed how essential it was to them to maintain contact with their infant and even perform skin to skin in the operating room. Many nurses are familiar with skin to skin in the delivery room, but are unsure how to incorporate such bonding

in the operating room. Nurses need to be educated how to allow for maternal infant bonding while performing the necessary operating room tasks and maintaining a sterile field.

Recommendations for Nursing Research

To improve the care of first time mothers having a planned cesarean birth further research should be conducted in several areas. Since this author's study contained only white well educated women additional studies should be conducted with women from varied socioeconomic and ethnic backgrounds. Furthermore, since cesarean birth rates and practices vary throughout the country further studies from different geographical regions should be conducted. In addition, since operating room policies vary between larger teaching hospitals and smaller community hospitals the research should be replicated in institutions of varying size.

The results of this author's study demonstrate the importance of adequate preparation. Some of the participants remembered receiving information, but could not comprehend it. Other participants discussed needing information other than what was provided. Future studies could address the educational needs of first time mothers having a planned cesarean. Further evaluation is also needed to assess the quality and timing of information being provided by healthcare providers. Participants in this study discussed not knowing what questions to ask or what information was missing. An intervention study to explore the usefulness of a peer mentor support group may provide the women with a feeling of increased knowledge and support.

Finally, additional research is needed to explore the thoughts and emotions of the support person. Some women in this study discussed how the fears of their support person prevented him from providing comfort. The women described feeling isolated and alone which led to an overall negative experience. Intervention studies to provide education and support to the support person may improve the support person's response during the cesarean birth.

Strengths and Limitations of this Study

This author's study has much strength. The use of narrative analysis reveals what was told and the cultural context in which the story was created (Riessman, 1993). The narratives are kept intact and analyzed as a whole. The subjective nature of childbirth and its importance in establishing maternal identity made narrative analysis a fitting method to capture first time mothers' experiences of a planned cesarean birth.

The participants were recruited from a variety of sources including: a local pediatrician's office, professional colleagues, and through snowballing. This recruitment strategy resulted in a sample representing four different states. This is significant since cesarean birth rates and practices differ between states. However all of the states represented were from the Eastern Coast of the United States and thus a sample more representative of the different geographical regions of the country may provide a more accurate depiction. In addition, all of the participants were white, married, well-educated women. The homogeneity of the sample is a limitation of this study.

Data collection is another strength of this study. Some of the participants crafted their story and sent it via email to the researcher. Email interviews allow time for reflection and thus may increase the detail of the story. Other participants chose to be interviewed face to face. The use of both Internet and in person interviews allowed for the triangulation of data, which provides a more truthful depiction of reality (Polit & Beck, 2012).

Conclusion

This author's study of the first time mothers' experiences of a planned cesarean birth provides unique insight. The literature reveals that planned cesarean births have not been studied in isolation, but rather have often been considered with emergent cesarean births. Furthermore

first time mothers are frequently studied with women undergoing subsequent deliveries. The experience of first time mothers having a planned cesarean birth is deficient in the literature. These mothers have specific physical, emotional, and educational needs. The results of this study can deliver healthcare providers an increased understanding of the experience. This may lead to the development of improved care and ultimately more positive experiences for first time mothers having a planned cesarean birth.

Summary

The presentation of the topic, first time mothers' experience of a planned cesarean birth commenced this dissertation. The background of planned cesarean births was discussed and a strong case was developed for the importance of the study. A detailed review of the literature was presented. Gaps in the state of the science were identified. Various methods to narrative analysis were described. The importance of utilizing Riessman's structural approach was discussed. The results were presented. The 11 individual narratives were described and the meta-story of first time mothers' experiences of a planned cesarean birth was portrayed. A discussion of the results within the framework of the literature review and Roy's Adaptation Model concluded the dissertation. Recommendations for nursing practice, nursing education, and nursing research were proposed. The dissertation concluded with an explanation of the strengths and limitation of the study.

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Table 1. Characteristics of Individual Studies Included in the Literature Review

Author(s) & year	Country	Discipline	Focus	Design	Sample
Arthur & Payne (2005)	New Zealand	Midwifery	Motivating factors for maternal request cesarean	Qualitative (phenomenology)	5 first time mothers who underwent a patient- initiated elective cesarean
Bloomquist, Quiroz, MacMillan, Mccullough, & Handa (2011)	United States	Medicine & Nursing	Maternal satisfaction	Quantitative	160 first time mothers who planned a vaginal birth and 44 who planned a cesarean
Bluml et al. (2012)	Austria	Medicine	Experience of planned cesarean	Qualitative (content analysis)	48 women with a planned cesarean birth
Bryanton, Gagnon, Johnston, Hatem (2008)	Canada	Nursing	Predictors of childbirth perceptions	Quantitative	652 women, 43.6% were first time mothers and only 26.7% gave birth by cesarean
Chalmers et al. (2010)	Canada	Nursing	Maternal satisfaction	Quantitative	6421 mothers: 45% were first time mothers, 75% delivered vaginally, 13.5% planned cesareans, & 12.8% unplanned cesareans
Fenwick, Gamble, & Mawson, (2003)	Australia & the United States	Nursing	Experiences of cesarean and VBAC	Qualitative content analysis	59 women who had a cesarean and/or a VBAC
Fenwick, Staff, Gamble, Creedy, & Bayes (2010)	Australia	Midwifery	Motivating factors for maternal request cesarean	Qualitative (thematic analysis)	14 first time mothers who underwent a patient- initiated elective cesarean
Fries (2010)	United States	Nursing	Experience of unplanned cesarean	Qualitative (phenomenology)	7 African American women who had an unplanned cesarean

Continue

Table 1. Characteristics of Individual Studies Included in the Literature Review

Author(s) & year	Country	Discipline	Focus	Design	Sample
Hobson, Slade, Wrench, & Power (2006)	United Kingdom	Psychology & Anesthesiology	Preoperative anxiety and postoperative satisfaction	Quantitative	85 women who underwent a planned cesarean
Kealy, Small, Liamputtong (2010)	Australia	Public Health	Recovery after cesarean	Qualitative (thematic analysis)	32 women who had at least one cesarean
Keogh et al. (2006)	United Kingdom	Psychology	Influences of expectations, control, & anxiety on women's experience of planned cesarean	Quantitative	65 women and their birth partners who had a planned elective cesarean
Kingdon et al. (2009)	United Kingdom	Medicine, Nursing, & Sociology	Women's views of maternal request cesarean	Mixed methods concurrent	443 first time mothers
Kolip & Butcher (2009)	Germany	Public Health	Involvement of first time mothers with decision-making for planned cesarean & satisfaction with information given	Quantitative	352 first time mothers who underwent a planned cesarean
Kornelsen, Hutton, Munro (2010)	Canada	Medicine	Influences on decision making	Qualitative	17 first time mothers who requested a cesarean birth
Lagan, Sinclair, Kernohan (2010)	United Kingdom	Nursing	Internet use in decision making	Quantitative	613 women who were pregnant or had given birth
Munro, Kornelsen, & Hutton, (2009)	Canada	Midwifery	Influence of birth stories in decision-making of elective cesareans	Qualitative	17 first time mothers who underwent a patient- initiated elective cesarean

Continue

Table 1. Characteristics of Individual Studies Included in the Literature Review

Author(s) & year	Country	Discipline	Focus	Design	Sample
Nerum, Halvorsen, Sorlie, Oian (2006)	Norway	Medicine	Counseling to decrease fear of birth as reason for requested cesarean	Quantitative	86 women requested a cesarean and expressed a fear of birth
Porter, Van Teijlingen, Chi Ying Yip, & Bhattacharya (2007)	Scotland	Medicine	Factors related to distressing cesarean birth	Quantitative Content analysis	521 women who had a cesarean birth
Puia (2013a)	United States	Nursing	Experience of cesarean birth	Qualitative (meta-synthesis)	10 qualitative studies resulting in a combined sample of 3721
Puia (2013b)	United States	Nursing	Decision making process	Quantitative	101 women who gave birth by cesarean: 45 repeat cesarean, 56 primary cesarean (23 scheduled, 32 unscheduled)
Redshaw, & Hockley (2010)	United Kingdom	Sociology	Experiences of care in relation to cesarean	Qualitative (thematic analysis)	2960 women who had given birth
Robson, Carey, Mishra, & Dear (2008)	Australia	Medicine	Motivating factors for maternal request cesarean	Quantitative	78 first time mothers who underwent a patient- initiated elective cesarean

Continue

Table 1. Characteristics of Individual Studies Included in the Literature Review

Author(s) & year	Country	Discipline	Focus	Design	Sample
Schindl et al. (2003)	Austria	Medicine	Birth experience: elective cesarean versus spontaneous birth	Quantitative	484 spontaneous vaginal deliveries, 41 vacuum assisted, 93 emergency cesareans, 103 elective cesareans for medical reasons, and 44 cesareans for psychological reasons.
Stadlmayr, Schneider, Amslerr, Burgin, & Bitzer, (2004)	Switzerland	Medicine	Variables influencing birth experience	Quantitative	251 women (180 vaginal births, 43 instrumental, and 28 cesarean)
Waldenstrom, Hildingsson, Rubertsson, & Radestad (2004)	Sweden	Nursing	Risk factors and prevalence of negative birth experiences	Quantitative	2541 women who had given birth, 1118 were first time mothers
Weaver & Statham (2005)	United Kingdom	Midwifery	The decision process and motivating factors	Qualitative (thematic analysis)	44 women who had decided antenatally to have a cesarean
Weaver, Statham, & Richards (2007)	United Kingdom	Midwifery	Decision making process	Mixed methods	108 women who had discussed cesarean birth prior to delivery
Wiklund, Edman, & Andolf (2007)	Sweden	Medicine	factors for maternal request cesarean	Quantitative	91 first time mothers who requested a cesarean
Wiklund, Edman, & Andolf (2008)	Sweden	Medicine	Difference in expectations between vaginal delivery and cesarean on request and breech cesarean	Quantitative	496 first time mothers (104 cesarean on request, 128 breech cesarean, 264 vaginal birth)

Continue

Table 1. Characteristics of Individual Studies Included in the Literature Review

Author(s) & year	Country	Discipline	Focus	Design	Sample
Wilde-Larsson, Sandin-Bojo, Starrin, & Larsson (2011)	Sweden	Nursing	Feelings and perceptions during delivery	Quantitative	739 women, 30 who had a planned cesarean and 47 who had an emergency cesarean
Wittmann-Price, Fliszar, & Bhattacharya (2011)	United States	Nursing	The decision process and satisfaction with choice	Mixed methods	50 women (15 cesarean births and 35 vaginal)

Table 2. Participant demographics and obstetrical characteristics

Participant	Maternal age	Age at decision	Present age of 1st child	Years of Ed	weeks pregnant @ decision	State where delivered	# of words	Length of interview in minutes
1	33	31	1	16	8	CT	1268	
2	37	30	6	16	16	CT	1288	
3	33	28	3	19	38 3/7	PA	1137	
4	46	41	4	16	0	CT	2384	40:49
5	33	26	6	16	0	PA	1479	12:41
6	33	33	4 weeks	18	32	CT	3282	26:53
7	32	31	3mo	19	38	NJ	1238	
8	32	31	5 1/2 mo	16	39	NJ	2663	28:56
9	28	28	7weeks	16	0	CT	3327	28:02
10	43	37	5	14	0	CT	3393	40:03
11	50	23	27	14	0	MA	972	30:51

Table 3. Overarching Themes

Overarching Theme One: The Decision, Not Much of a Choice	
Subthemes for overarching theme one	
1. Influence of birth stories	
2. Safety of the baby	
Overarching Theme Two: Acceptance of Birth Method	
Subthemes for overarching theme two	
1. Healthy baby	
2. Faith and support	
Overarching Theme Three: Emotional Roller Coaster Of Birth	
Subthemes for overarching theme three	
1. Fear	
2. Doubt	
3. Denial	
4. Calm	
5. Joy	
6. Relief	
Overarching Theme Four: Physical Recovery, Feeling Like Myself	
Subthemes for overarching theme four	
1. Presence of support	
2. Physically active/fit	
3. Breastfeeding difficulties	
Overarching Theme Five: Emotional Recovery, A Kaleidoscope of Feelings	
Subthemes for overarching theme five	
1. Presence of support	
2. Breastfeeding difficulties	
Overarching Theme Six: Expectations, A Picture in my Mind	
Subthemes for overarching theme six	
1. Importance of prior information	
2. Role of healthcare providers	
Overarching Theme Seven: Outcomes, Ties That Bind	
Subthemes for overarching theme seven	
1. Improved relationships	
2. Happy to be a Mom	

Figure 1. Conceptual-empirical-theoretical structure for the study of perceptions and responses to a planned cesarean birth.

