

**Responding to Emergency Cesareans: How do Social Responses Influence  
Psychological Well-Being?**

By

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## Abstract

Many women who have emergency cesarean births appraise their births negatively or even as “traumatic.” While other women who have them appraise their birth experience quite positively. The researcher set out to investigate possible explanations for the variance in appraisals and experiences. A specific aim of the study was to determine what type of relationship exists between the types of social responses women are provided and their postpartum psychological state. Women’s responses to an emergency cesarean birth were observed. The types of negative and positive social responses they received from social actors, and their responses to them were also investigated. Semi-structured response-based interviews were conducted with six participants. Both a thematic analysis and a contextual case study analysis were used. A thematic analysis was used to identify the types of social responses women received, and then a response-based contextual analysis research framework, was used to conduct a case study analysis. The main types of social responses to the participants were identified as being (or not) emotionally supportive, supportive of agency, and supported of recovery. The majority of the participants appraised their birth experience positively. Analysis of the findings found an association between receiving positive social responses and postpartum psychological wellbeing. A connection between negative social responses and women’s responses of resistance was also identified. The findings suggest that women’s experience of having an emergency cesarean birth are connected to a complex web of social interactions.

Keywords: childbirth, trauma, birth trauma, social interactions, caesarean section, caesarean birth, unplanned caesarean, emergency caesarean, disclosure, social support, social responses, PTSD, posttraumatic stress disorder, psychological harm, pregnancy, postpartum, resilience, risk

factors, psychosocial, emotional, mother(s), maternity care, postpartum care, counselling, labour, response-based practice, birth story.

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## Dedication

I would like to dedicate this work to all the people who have experienced an emergency cesarean birth, especially the participants of this study who generously shared their experiences and the beautiful and intelligent ways they responded to having an emergency cesarean, despite intending to have a vaginal birth. I hope their wisdom and teachings will be used to enhance the childbirth and postpartum experiences of other women who journey along this path into motherhood. I hope this thesis accurately recognizes and acknowledges the effort, strength, and courage women put forth to bring their babies into the world through a surgical birth.

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## Chapter One: Introduction

### Background

Childbirth and the transition to parenthood is a profound experience for most people. A positive childbirth experience can be recalled as an empowering and life-changing event (Nilver, Begley, & Berg, 2017, p. 1) while a negative experience may be met with a sense of loss and may disrupt the transition into parenthood (Nilver et al., 2017, p. 1). Some women have identified childbirth as being a traumatic experience (Beck, 2009). Findings from previous research estimate that approximately one third of women who give birth experience some type of posttraumatic stress disorder (PTSD) symptoms (Vossbeck-Elsebusch, Freisfeld, & Ehring, 2014; Beck, 2009; Ayer, 2017). A further, 1.5% to 6% of women develop PTSD (Vossbeck-Elsebusch et al., 2014; Beck, 2009; Ayers, 2017). Of the many risk factors identified in previous research, having a subjectively negative birth experience, an operative birth (i.e. assisted vaginal or cesarean section), or a lack of support during birth are most associated with birth trauma and PTSD (Ayers, 2017).

Childbirth following an operative cesarean birth has been associated with negative psychological and emotional responses among women (Gamble & Creedy, 2009; Ryding, Wijma, & Wijma, 1998; Yokote, 2008; Van Reenen & Van Rensburg, 2015). Moreover, childbirth following an emergency cesarean birth presents as a key predictor for PTSD (Johnston-Robledo & Barnack, 2004). While some women who experience a cesarean birth develop symptoms of post-traumatic stress disorder and/or a diagnosis of PTSD, other women do not develop negative psychological outcomes associated with PTSD (Ryding, Wiren, Johansson, Ceder, & Dahlstrom, 2004; Van Reenen & Van Rensburg, 2015). In fact, there are many women

who respond with a positive post-cesarean psychological profile and appraisal of their birth experience (Clement, 2001; Van Reenen & Van Rensburg, 2015).

### Statement of Problem

Currently, it is not clear why only some women have negative psychological appraisals of emergency caesarean births while others view their emergency cesarean births positively. What is well known however, is that an increasing number of women are receiving cesarean births in British Columbia and across the country. In 2015, the cesarean rate in the province of British Columbia was 35.9%, and 32.9% in the Greater Victoria region (Province of BC, 2015).

According to a report conducted by the Perinatal Services BC (2016) 48.5 % of cesareans in BC in 2015/16 were primary emergency. To put this into perspective, the World Health Organization recommends that cesarean rates range between 10%-15% (WHO, 2015). Considering the rise in cesarean births across the country and the relationship between them and the perceived negative psychological outcomes for some women, research needs to be conducted to gain better insight into women's post-cesarean responses.

Studies that examine why it is that some women develop a trauma response to emergency cesarean births are limited and tend to focus on two broad areas: intra-individual factors and social factors. Studies that focus on intra-individual factors as the cause for more traumatic symptomology looked at factors such as, women's psychological state before the birth (Wijma, Ryding, & Wijma, 2002), fear of giving birth (Johnston-Robledo & Barnack, 2004), level of confidence, women's relationship between expectations and experience (Ryding, Wijma, & Wijma, 2000), and women's subjective experience (Herishanu-Gilutz, Shahar, Schattner, & Kofman, 2009). All of these studies locate the pathology of the problem within the individual.

This is problematic because this practice is based on the presupposition that something is inherently wrong or lacking within these individuals.

Other studies that consider the social aspect of having an emergency surgical birth investigate the role that various social factors, such as social support (Noyman-Veskler, Herishanu-Gilutz, Kofman, Holchberg, & Shahar, 2015) and the quality of relationships (Radosti, 1999), play in the development of psychological stress or wellbeing. Much of the language used in these studies construct social support as a ‘buffer’ against the effects of emergency cesarean births and/or they posit that social factors can be ‘protective factors’ against poor psychological outcomes. The problem with this perspective is that they view people who experience childbirth as passive objects in need of protection, when in fact, they are active, responding social agents.

### Language of Effects

The field of psychology and counselling often view some women’s responses to childbirth through a lens of pathology and within a context of diagnosis of symptomology. Many of women’s responses have been interpreted as effects and cast as symptomology related to disorders commonly understood and known as postpartum depression, postpartum anxiety, and posttraumatic stress disorder (PTSD) as classified in the Diagnostic and Statistical Manual of Mental Disorders (DSM). By interpreting and misrepresenting peoples’ ways of resisting and responding as effects, resistance is transformed into problems, problems are labelled as symptoms, and symptoms are categorized as disorder (Todd & Wade, 2004). This use of effects-based language and perspective is prevalent in much of the literature and findings previously discussed in this paper up to this point.

Effects-based language has been defined as any use of a linguistic device, figure of speech, metaphor or term, that implies an individual's behaviour or actions are the effect of a cause (Wade, 2002). Furthermore, Todd and Wade (2004) caution that the language of effects misrepresents victims' responses and conceals the ways in which they resist. From this perspective, the context people who have had an emergency cesarean are responding to is often decontextualized and their agency and capacity to actively respond is concealed.

### Response-Based Practice

Response-based language differs from the language of effects in that it presupposes that people have agency to respond to and resist an adverse event (Coates & Wade, 2015). Response-based practice is concerned with contextualizing the details of social interactions to elucidate agency and resistance (Coates & Wade, 2015). When resistance and responses are understood in context, the situational logic becomes transparent and intelligent (Richardson, 2016). In the current context of childbirth, contextualized postpartum responses such as postpartum depression or postpartum anxiety become understandable as intelligent responses and acts of resistance. By focusing on the details of women's responses to childbirth, many actions and subjective experiences that were previously ignored or misrepresented as effects of childbirth are permitted new importance as responses and acts of resistance.

### Social Responses

The relationship between psychological well-being and the quality of social responses received is a predictor of the severity of distress experienced by trauma survivors (Ullman & Filipas, 2001). Disclosing a traumatic event can elicit positive social responses and beneficial support. However, negative social responses have been connected to more severe trauma symptomology, particularly in terms of the responses given upon disclosure (Ullman & Filipas,

2001). This tells us that women do not make meaning out of their experience of cesarean births in isolation. The meaning making process is inherently social and mediated by the meaning other social responders convey to women about cesarean births. Women assess how to respond after considering the meaning others ascribe to their experience. As such, women's experiences are best understood by viewing them in the context in which they occur.

### Social and Medical Discourse

A means to understanding the context in which people experience cesarean births is to assess the influence of social and medical discourse on their experience. Medical discourse is a social response in itself. In the context of this study, one way it operates is through social messages about the female body and cesarean births. Social and medical discourse can put pressure on women to perform during labour as well as to have a vaginal birth. It is important to identify the ways in which women react to social responses embedded within medical discourse to better understand their experience of childbirth.

Social responses provided by institutional actors (medical professionals) to women and their social network likely influence not only the women's responses but her entire social network's response. Similarly the social network's responses influence institutional actors on a micro level within an institutional macro system. Furthermore, from a systemic perspective, it is important to understand social interactions within the context of the medical system while recognizing the power imbalances that may be at work within the system. Childbirth is a nuanced process involving many social interactions—much meaning making occurs on the micro level within the institutionalized macro system.

### Significance of Study

Examining the social responses that women receive, and the ways in which they respond to these social responses during childbirth and postpartum is important for several reasons. First, it will inform practitioners of the helpful and unhelpful social responses women were given. Second, understanding the ways in which people respond to having a cesarean birth and the social responses they receive during and after childbirth, helps practitioners better understand postpartum behaviour as responses, not symptomology. Concerned practitioners can use these findings to inform the way they work with people who require or have experienced a cesarean birth. It is useful for practitioners to know how to work with and respond to clients in a way that does not produce psychological harm and instead promotes healing and agency. Furthermore, when therapists are knowledgeable about the various psychological issues that many childbearing people are faced with during pregnancy, birthing, and the postpartum period, their client's psychological well-being can be greatly supported (Johnston-Robledo & Barnack, 2004).

### Purpose of Study

Given the limitations of existing research in the field it is clear that a need for analysis of social responses within the context of childbirth is needed. This will be done with an intentional distancing from the common pathologizing practice of decontextualizing people's experiences and transforming behaviour into symptomology found in the field of psychology and counselling. Throughout this study, I explore women's responses to childbirth and the social responses they were given through a response-based perspective. When viewed through a response-based perspective, much of what is considered psychological disfunction or mental health symptomology can be interpreted as an understandable response to the social responses given during childbirth and postpartum.

The intent of this study is to explore people's experiences and perceptions of emergency cesarean births in an effort to better understand how they respond and make sense of their experience and the social responses they are provided. This study will first look at the negative and positive social responses women are given during childbirth, surgery, and postpartum. Then a contextualized analysis will be carried out, paying attention to the ways in which the participants responded to their experience and the social responses they were provided. The broad research question is: Do the responses women receive while disclosing their experience of emergency cesarean births influence the development of trauma reactions and/or PTSD symptoms? There was an interest to see if there is a relationship between the social responses given to people during childbirth and postpartum, and psychological wellness or harm.

This broad question was broken down into the following questions:

1. What types of positive and negative social responses are provided to people during childbirth and in the postpartum period?
2. How do women respond to the social responses they are given in childbirth and postpartum?
3. How do women respond to childbirth by emergency cesarean?

## Process

This paper consists of a total of five chapters. Chapter 2 will contain an overview of the relevant literature. Chapter 3 will provide a detailed account of the methods and methodology used to conduct this study. Chapter 4 will describe the results and findings. Chapter 5 expands on the discussion of the results and findings in Chapter 4.

## Defining the Terms

**Emergency cesarean section:** a surgical obstetric intervention and birth, despite the labouring person's desire to have a vaginal birth. This term will be used interchangeably with C-section, surgical birth, and cesarean birth throughout this paper.

**Women and People:** Throughout this paper I will switch back and forth between referring to women and people. This is done in an effort to be inclusive of people who experience childbirth but do not identify as a woman.

## Chapter Two: Literature Review

This chapter will review the current literature concerning women's experiences of childbirth, the social responses they are provided, and how they, in turn, respond to those social responses. It is necessary to examine the research to better understand how people respond to childbirth (or other potentially traumatic events) and the social responses they were provided. The literature used to conduct this study was accessed through the City University Library. The following databases were used: ERIC, EBSCO, ProQuest, PsychBOOKS, PubMed, Sage, Taylor & Francis and Cochrane. Journals used include: *Obstetrics & Gynecology*, *Birth*, *Journal of Perinatal Medicine*, *Lancet*, *Pediatrics*, *JAMA*, *Reproductive Infant Psychology*, *Infant Mental Health Journal*, *British Journal of Psychiatry*, *Journal of Anxiety Disorders*, *Canadian Medical Association*. Search terms include: *childbirth*, *trauma*, *birth trauma*, *social interactions*, *caesarean section*, *caesarean birth*, *unplanned caesarean*, *emergency caesarean*, *disclosure*, *social support*, *social responses*, *PTSD*, *posttraumatic stress disorder*, *psychological harm*, *pregnancy*, *postpartum*, *resilience*, *risk factors*, *psychosocial*, *emotional*, *mother(s)*, *maternity care*, *postpartum care*, *counselling*, *labour*, *response-based practice*, *sexual assault*, *veterans*, and *birth story*.

After a review of the literature, I was not able to identify any studies that focused exclusively on the social responses women are given throughout a surgical childbirth and postpartum nor was there any research found that examines their responses to the aforementioned social responses. The relationship between social responses given during and after cesarean births, and women's responses to them, specifically as it pertains to psychological wellbeing, has yet to be explored in this context. As such, this literature review will assess previous studies and articles that examine the relationship between social responses and

psychological outcomes in other fields of work. It will also look at studies that explore the types of responses people were provided, medical discourse as a social response, and social responses to childbirth in general. Finally it will end with a review of work done on women's experiences of cesareans.

### Social Responses to Trauma Disclosure and Psychological Outcomes

Previous studies exploring responses to trauma have been conducted with sexual assault survivors (Relyea & Ullman, 2015; Lorenz, Ullman, Kirkner, Mandala, Vasquez, & Sigurvinsdottir, 2018; Ullman & Filipas, 2001), veterans (Schumm, Koucky, & Bartel, 2014), people with stigmatized identities (Chaudoir & Fisher, 2010) and women who experienced pregnancy loss (Swanson, 1999; Cecil, 1994; Cosgrove, 2004). Much of this work views the trauma survivor's responses as pathology and as an effect of the adverse event. Nonetheless the findings from these studies inform the current study as they provide examples of some types of social reactions or social responses, and the responses to these social responses (although mostly cast as pathology) have been elucidated.

The disclosure of trauma, in some cases, can elicit positive social responses and beneficial support. Without disclosing the adverse event to others, the trauma survivor bears the burden of trauma in isolation. However, not all disclosures result in positive social responses and the act of disclosing can influence the level of distress experienced by the discloser. A study by Ullman and Filipas (2001) examined the severity of PTSD and social reactions in sexual assault victims. The findings demonstrated a relationship between receiving positive social reactions with less severe sexual victimization and more severe sexual victimization with the provision of negative social reactions. Put another way, the quality of social responses survivors received is connected to the severity of distress experienced (Coates and Wade, 2015).

These findings are similar to other studies which argue that the social response of the confidant is a key factor in determining the usefulness of disclosure (Major, Cozzarelli, Sciacchitano, Cooper, Testa, & Mueller, 1990). For instance, in a longitudinal study by Major et al. (1990) investigating women's disclosure of abortion, no demonstrable reduction of psychological distress was observed in women who did not feel supported by the person to whom they disclosed. In her work in the field of pregnancy loss, Swanson (1999) observed a relationship between the quality of responses from medical personnel and obstetric teams to women following miscarriages and stillbirths. This is congruent with other findings that women responded with feelings of disappointment, felt isolated, and/or silenced by the lack of emotional response and availability from medical professionals (Cecil, 1994). Women's experience of loss was acknowledged but no emotional support was provided.

In a study exploring associations between social reactions to trauma among veterans seeking treatment, Schumm et al. (2014) found that the social responses provided to trauma survivors are distinct. Additionally, they argue that they found evidence supporting the notion that critical and unsupportive social responses are connected to survivor PTSD. The findings of the study support other research by suggesting that perceptions of social responses are used by trauma survivors to make meaning of their experience and these perceptions are linked to psychological outcomes. Schumm et al. (2014) draw a comparison between these findings and the disapproving and unsupportive social reactions given to Vietnam combat veterans upon homecoming. The responses they were provided were perceived negatively, and in turn, the veterans experienced more severe psychological distress. This connects to Coates and Wade's (2015) suggestion that the type of victim responses is indicative of the social responses they have been given, and the meaning they have ascribed to adverse events by social responders, as it does

about the experience of the event. It is clear that survivors do not make meaning of their experience in isolation.

Considering the potential for trauma survivors to be given negative social responses, it is no wonder people struggle to, or refrain from, disclosing to another person at all. The unfortunate implications, however, of not disclosing is that the trauma survivor may not get the support they need. This was discussed in a study by Chaudoir and Fisher (2010) examining disclosure among people with stigmatized identities. They found that disclosure influences well-being as it is required to gain social support. The decision to not disclose in an effort to protect oneself from social rejection limits access to potential emotional and physical supports from the social responder.

#### Types of Social Responses & Responders

Social responders have the potential to support or exacerbate psychological well-being in trauma survivors. In a study by Ahrens, Cabral, and Abeling (2009) they found that support provided by counsellors and friends, in the form of tangible aid and emotional support, were perceived as more therapeutic. Where negative social responses were experienced as more harmful when given by significant others and family. Additionally, they found that friends tend to provide the most positive and often the best responses to survivors. A more recent study by Lorenz et al. (2018) found similar results in that positive responses were provided more than negative responses by friends. Overall, friends provided more positive responses than significant others and family. Female friends, more often than male friends, significant others, and family, reacted positively as they shared a similar experience with and understanding of trauma.

In the study by Relyea and Ullman (2015) at least two types of negative responses were discovered: being turned against and unsupportive acknowledgement. Examples of 'turned

against' include being blame, stigmatized, or infantilized. Survivors who were given these types of responses had poor psychological outcomes. Survivors who were provided acknowledgement without support responded with maladaptive and adaptive coping practices. 94% of women in the study were provided responses of acknowledgement but did not receive support after disclosing an assault. Survivors responded to the lack of support with diminished coping than with more hostile responses.

Other negative social responses that have been identified in Schumm et al.'s (2014) work with veterans that may be relevant to the current study—especially in regard to the postoperative pain people who have cesareans experience—are social responses that don't recognize and acknowledge the severity of the trauma survivors experience, and that the negative consequences of trauma are not understood.

### Medical Discourse as a Social Response

The context of medical discourse, specifically the language used in reproductive health surrounding pregnancy and childbirth, operates as a social response. Pregnant and laboring people interact with this discourse throughout their childbearing experience, which in turn, influences how they make sense of their experience. Similar to how trauma survivors make sense of their experience through the social responses given to them by social actors, people who experience childbirth makes sense of their experiences through medical discourse, as well as the social responses they are provided from people. Although not specific to cesarean births, a study that speaks to the operation of social discourse throughout pregnancy was conducted by Cosgrove (2004) who reviews the psychosocial literature on perinatal loss from a critical feminist perspective. The main theme of this article is concerned about the medical context in which women who experience pregnancy loss are rooted. She argues the language used within

the medical model upholds pathology and neglects to reflect their lived experience. She suggests that, in an effort to honour women's meaning making process, it is essential to challenge the epistemological framework prevalent in biomedical discourse. She argues that professionals need to situate the women's experience within the medical and social context in which it exists. The following analysis by Zita (1998) fits with Cosgrove's (2004) argument, "The medicalized female body, constituted as an object of interest for the medical gaze, is removed from the social and ideological contexts in which it is lived and interpreted" (p. 108).

Such a critique of the epistemological framework of biomedical discourse is provided by Lauren Hunter (2006). She uses a feminist lens to argue that the dominant discourse in Western childbirth is built around the biomedical model that emphasises pathologies in need of diagnoses and treatment. She points out that this model is underpinned by three Cartesian principles: First, the mind is separate from the body and they cannot influence the other. Two, physical nature is viewed mechanistically. The body is viewed as a machine that can be repaired by medical intervention. Finally, it is based on logic and rationalism to the exclusion of emotive language and contextual information. Childbirth from this perspective, is deemed a risky pathological condition that necessitates the need for privileged medical knowledge and the subjugation of women's bodily autonomy and agency.

Hunter (2006) also highlights the ways in which language is used to pathologize female bodies by viewing them as passive objects without agency. The medicalization of birth is founded on language laden with pathologizing and pejorative terms. The following quote provides examples of terms that are used to pathologize the female body in labour while privileging obstetric knowledge.

Disempowering and pejorative terms that emphasize the poor quality of the uterine “machine,” women’s inability to give birth, and the ability of obstetric language. For example, the process of the fetus traveling through the birth canal is referred to as “the mechanism of labor.” A woman’s labor that does not progress on a specific timetable is referred to as “arrested.” If “active management” is unable to speed the progression of labor, the process is referred to as a failure, as in, “failure to progress.” Contractions of the uterus can be labelled “inadequate” or “false,” and the cervix can be considered “unfavourable” or “incompetent.” A woman’s gestational term is called “confinement,” and babies are “delivered” by the provider, not “borne” by the mother (Hunter, 2006, p. 121).

These terms illustrate the pressure placed on women to perform during childbirth. The ways in which medical discourse works to discourage agency and elicit fear and doubt in women about their body’s capacity to birth babies, becomes clear upon reading this passage. This type of language is saturated in the biomedical model that is the context in which women are experiencing childbirth. The social messages relayed to women who have cesarean births is that their bodies have failed them, when in fact childbirth is much more complicated than that and the blame for cesarean births should not be assigned to these women’s “failed attempts” at vaginal births.

### [Social Responses to Traumatic Childbirth](#)

Previous research has been conducted by Sharp (2018) on the relationship between disclosure of a traumatic birth experience, and the social responses women received, and how these responses contribute to the maintenance of psychological stress such as PTSD or postpartum depression. Using a mixed methodology, Sharp (2018) specifically looked at the

rates at which women who experience a traumatic birth choose to disclose their experience and the unsupportive responses received from social partners. Another aim of this study was to examine associations between disclosure of traumatic experience and specific psychological functioning such as maladaptive coping, posttraumatic cognitions, and depression and PTSD symptomology. Congruent with other findings already discussed in this chapter, the findings of this study revealed a connection between unsupportive social responses to disclosure of a traumatic birth experience, and the severity of psychological distress associated with childbirth. The themes of negative social responses that were identified were minimizing, blaming, and lack of support. These themes are similar to those reported from people who disclosed after other types of trauma.

Almost all of the participants in the study used disclosure as a way to cope with their difficult childbirth experience. The author found that women intentionally chose not to disclose as a way to protect themselves from being given a negative social response. This is notable as it demonstrates that women who receive positive social responses to disclosure are likely to feel emotionally supported. However, if women fear they will be given a negative social response they chose to withhold their disclosure. This is a concern as women who don't disclose may not be able to access the emotional support they may need after a cesarean birth.

Most of the women disclosed to someone from within their social network, although some chose to disclose to a medical or mental health professional. Women also reported not disclosing as a result of not having any one they felt comfortable enough to disclose to. Sharp's research highlights the need for mental health supports as a part of obstetric and gynecological practices.

[Experiences of Cesarean Births](#)

Some studies have investigated women's responses to having a cesarean birth, although they do not explicitly discuss the types of social responses women were given, they do provide some insight into how women respond to having an emergency cesarean birth. A study by Ryding et al. (2000) investigated women's experiences of emergency cesarean sections, and categorized the emerging patterns, and the relationship between the patterns, traumatic delivery experience, and posttraumatic reactions. The sample included 25 women between the ages of 23-42 years who were interviewed a few days after delivery on the maternity ward, and, then again 1-2 months later. The first pattern identified was that the women who never lost confidence in themselves or staff did not experience their delivery as a mental trauma or show any signs of posttraumatic stress reactions. The second pattern identified women, whose positive expectations turned into disappointment, did experience their delivery as a mental trauma, some of which required treatment for posttraumatic stress reactions. The third pattern revealed that the women whose fears came true (i.e. that something was wrong, and they needed to have a cesarean section) did experience their delivery as a mental trauma and some showed signs of posttraumatic stress reactions. The fourth pattern showed that some of the women who experienced confusion and amnesia did experience their delivery as a mental trauma but did not show signs of posttraumatic stress reactions at the second interview.

A study by Kjerulff and Brubaker (2018) focused on women's experience of childbirth as it relates to the mode of delivery. The objective of the study was to examine how women felt about their first childbirth experience. This was a prospective cohort study of 3006 women who were interviewed during pregnancy and 1-month postpartum. The key relevant results revealed that the women who had emergency cesareans were more likely to have the least positive feelings when compared to those who birthed their baby through other means. Many women

responded to their experience of having an emergency cesarean with feelings of disappointment and a sense of feeling like a failure. They were less likely to feel proud about their birth experience than women who gave birth vaginally. The researchers concluded that cesarean births negatively affect women's self-esteem and influence how women view their first childbirth.

A study by Van Reenen and Van Rensburg (2015) investigated South African women's experiences of having emergency cesarean births, with a focus on coping. A thematic content analysis was used to identify four main themes of coping: information, control, and support. The provision of information about cesareans prior to surgery helped women feel prepared and was connected to postpartum wellbeing. Participants felt in control of the birth to the degree in which they felt prepared, informed, and had their decision-making role respected. Social support, in particular that from their husbands, was a source of comfort and security. Family and friends' provision of practical and emotional support was identified as a valuable source of support for women. The relationship with caregivers contributed significantly to women's appraisal and perception of their birth. A notable finding was that religion was found to be a predictor of a positive birth experience. The study also demonstrated that the passage of time improved the participants' perception of a negative birth experience.

### Summary of the Literature Review

Within the literature that examines how people respond to the social responses they are given throughout a potentially traumatic event, or upon and after disclosure, it is clear to see that a paramount theme is that the quality of social responses given influences the way in which people will make sense of the traumatic or adverse event. People do not make sense of adverse events in isolation; it is a social process. Negative social responses have been connected to poor psychological outcomes and positive social responses support psychological well-being. People who experience emergency cesarean births make sense of their experience through the social

responses they are provided, including the medical discourse and context within which childbirth exists. Much of the literature reviewed uses a language of effects and is grounded in the biomedical model which is based on identifying and treating pathology. As such, a gap has been identified in the research: no previous studies have examined the social responses women are given during childbirth and upon disclosure of having an emergency cesarean. Furthermore, no existing research uses a response-based lens to investigate women's responses to the aforementioned social responses.

## Chapter Three: Methods

### Introduction

The aim of this study is not to prove or refute hypotheses or to test a preexisting theory; rather it focuses on the generation of data with the intention of understanding the types of social responses women who have had an emergency cesarean received during childbirth and in the postpartum period and to examine, in turn, how women respond to these social responses. The final aim is to determine if there is a relationship between the types of responses they receive and their psychological well-being. To this end, I used a qualitative research approach to design and conduct interviews. A response-based contextual analysis framework informed the research design. This chapter will explain my research approach and rationale, target population, ethical considerations, data collection procedures, data analysis, and the limitations of this study.

### Research Approach and Rationale

**Qualitative research.** Very little is known about the psychological implications of the social responses women receive while disclosing their experience of an unplanned cesarean. Qualitative research is appropriate in studies where a "...concept or phenomenon needs to be explored and understood because little research has been done on it..." (Creswell, 2014, p. 20). How women make sense and meaning out of the responses they receive from social partners after disclosing details about their emergency cesarean has not been studied and is not well understood at this time. A qualitative research design was selected for this study because it is an approach that is well suited to "...exploring and understanding the meaning individuals or groups ascribe to a social or human problem" (Creswell, 2014, p. 4).

**Response-based practice (RBP).** RBP is an approach used to understand the ways in which individuals respond to and resist adverse social interactions and events (Wade, 2015). RBP

comes out of work with victims and perpetrators of violence and is applicable to working with people who have faced challenging and adverse events in their lives (Wade, 2015). As such, the questions used to elucidate women's experiences with having an emergency cesarean birth, and the responses they received upon disclosure of their experience, will be informed by many of the concepts found in response-based practice.

Much of the mainstream discourse on trauma (after childbirth) uses a language of effects (Gamble & Creedy, 2009; Ryding, et al., 1998; Yokote, 2008; Van Reenen & Van Rensburg, 2015; Beck, 2009; Ayers, 2017), which contains the embedded presupposition that people are passive agents who are 'acted upon,' whereas a response-based practice perspective holds the embedded presupposition that people are active, responding agents, who resist adverse treatment (Wade, 1999; Richardson, 2016). Often many of the ways people respond to and resist trauma are misrepresented as problems or pathologies. Viewing peoples' thoughts, feelings, and behaviour as effects shifts the focus away from contextual factors to the goal of treating psychological 'effects' instead (Wade, 1999). In short, the focus becomes about fixing the individual, rather than viewing their thoughts, feelings, or behaviours as a reasonable response to a bad situation. Wade (1999) reasons that when human action is interpreted as responses to context and situations, instead of effects, we become interested in assembling information about the contexts, situations, and people's responses to them.

*Theoretical orientation.* I decided to design this study around concepts of RBP because I noticed much of the literature on postpartum depression, anxiety and PTSD locates the problem or the source of these psychological symptoms within postpartum women and people (Gamble & Creedy, 2009; Ryding et al., 1998; Yokote, 2008; Van Reenen & Van Rensburg, 2015; Beck, 2009; Ayers, 2017). My personal biases align with the presupposition embedded in RBP, that

psychological symptoms are a response to some aspect of a significant interaction or event in the life of the person presenting with psychological distress. The presuppositions that I bring into this study are influenced by the response-based practice notion that symptoms are most often a response and an act of resistance towards adverse interactions occurring in an individual or community's life. From this perspective, symptoms of "anxiety," "depression," and "trauma" experienced soon after childbirth, and in this case, emergency cesarean births, may be a response to some aspect of the childbirth and postpartum experience.

Psychological healing occurs when the symptoms are traced back to the originating event or social interaction and understood within the context people are responding to; this provides an opportunity for responses and resistance to be elucidated and dignity restored (A.Wade, personal communication, February 17, 2018). When symptomology is viewed as responses and resistance to negative social responses, a more contextual and accurate assessment and understanding of the postpartum psychological state becomes possible.

### Description of Participants

The convenience sample of participants for this study were comprised of six, white, middle-class women who had an emergency cesarean delivery within the last three years. Ages ranged from 29-37. Four of the women were married and the other two were in common-law relationships. Five of the participants were in heterosexual relationships and one was in a relationship with a transgendered male. The gravidity of five of the participants was primipara (primip) and one participant was multiparous (multip). All of the participants had planned their pregnancies. Five of the participants planned to give birth in a hospital, and one had planned for a homebirth. Three of the participants had doctors and three had midwives as their primary care providers. Four of the participants hired doulas.

### Inclusion and Exclusion Criteria

Inclusion and exclusion criteria required the following of the participants: 1) 19 years-old or older, 2) Experienced an unplanned emergency cesarean within the last three years, 3) The baby did not have neonatal complications, 4) It was a planned pregnancy, 5) Did not have any mental health concerns or diagnoses before or during pregnancy. The last three criteria were informed by past studies that addressed the need to control for these characteristics as they may influence the psychological state of participants. Unplanned pregnancies, prior mental health challenges, and having a baby with neonatal complications are factors that can influence the psychological state of postpartum people and their experience of childbirth and becoming a parent.

Throughout the recruitment phase I decided to make exceptions to the criteria for participation in order to increase the number of participants. I decided to include a participant who had an emergency cesarean past the three-year criterion. I made the decision to include her because she was only two months past the 3-year cut off. Another area where I made an exception to the criterion was in the area of mental health. While conducting interviews, three of the participants disclosed they had experienced symptoms of depression prior to their pregnancy. However, two of the participants did not consider their symptoms of depression to be a concern and they did not receive a diagnosis. One of the participants, experienced depression briefly after the birth of her first child. Another exception was for a participant whose baby was temporarily placed in NICU for observation because it was born prematurely. Otherwise, the baby was healthy without neonatal complications.

### Recruitment

The participants for this study were recruited through a recruitment flyer shared within my network of birth professionals and parents and in local new parent groups on Facebook. See *Appendix A* to view a copy of the original flyer.

### Ethical Considerations

This study was reviewed and accepted by a Research Ethics Board (REB) through City University of Seattle before commencement. All of the participants were told the purpose of the study and were required to review and sign a consent form prior to their participation. Participants were told of the slight chance of psychological distress they might feel in response to some of the interview questions that asked them to recall details about prior difficult experiences. They were informed they could decline to answer any question. It was also made known they could withdraw their participation or inclusion of their data from the study without penalty. Resource referrals were available in the case that a participant required counselling support.

Confidentiality was discussed, and the participants were told that any information they shared with me would be kept confidential. Participants were made aware that their information and stories would be confidential and any identifying information would naturally be changed and deidentified. All identifying information has been removed including information about what, if any, parenting group the participant attended, the name of their primary caregiver(s) and maternity health professionals, the name of any counsellor(s) or agencies they sought support from, details about their obstetrical history, names of children and partners, and any other identifying information.

### Data Collection Procedures

Data collection involved qualitative face-to-face, in-depth and in-person interviews with people who have experienced an emergency cesarean birth. I met with some of the participants in their homes and three of the participants were interviewed at a local office space. The duration of the interviews ranged from 30-90 minutes. Semi-structured interviews were conducted, audio-taped and transcribed by the researcher.

*Research instruments.* A semi-structured questionnaire was used to guide the interview and was divided into two sections. The first section included demographic questions about the clients, age, gender, race, ethnicity, employment, relationship status, etc. Additional closed-ended questions inquired into the participant's preferred birth setting (home or hospital), primary caregiver, other supports, interventions, previous pregnancies and births, mental health before and during pregnancy, planned or unplanned pregnancy, examples of common negative social responses, whether they have symptoms or a diagnosis of postpartum depression, postpartum anxiety, and/or post-traumatic stress disorder and whether or not they experienced the birth they had hoped for.

The second section of the questionnaire included questions adapted from the *Response-Based Contextual Analysis Framework* (Bonnah, Coates, Richardson & Wade, 2014). Open-ended questions were asked to examine the social responses participants received after disclosing information, about their experience of having an emergency cesarean birth to other social actors. The responses participants received before and during the cesarean were also included. I aimed to gather a detailed account of how participants made sense of their emergency cesarean births, and the responses they received from others, and how these responses influenced their perceptions of their births. The following is a list of the main questions asked: (1) How did you come to know you would need an emergency cesarean birth? (2) How did you respond to hearing

that you would have to have a cesarean delivery? What did that mean to you? (3) Was anyone else present when you found out you would need an emergency cesarean delivery? If so, how did they respond to hearing this? (4) How did the other medical professionals respond upon learning you would need to have an emergency cesarean birth? (5) Who else knew that you needed an emergency cesarean? How did they respond to hearing that you would need a cesarean delivery? (6) Who have you talked to, or debriefed with, about having an emergency cesarean birth? (7) What details about the birth have you shared with other people (e.g. parents, friends, medical staff, family, etc.)? How did they respond when you told them about the details of your cesarean birth? (8) How did you respond to the responses you got from the people you told? (9) Which responses were helpful to you? Can you tell me why you found these responses helpful to you? How did you respond to the helpful responses? (10) Which responses were unhelpful or harmful? Can you tell me why you found these responses unhelpful or harmful to you? How did you respond to the unhelpful responses? (11) How do you make sense of your decision to respond this way? (12) Is there anything else you think would be useful for me to know about your experience? Follow up questions were asked inquiring into how the participant responded to the social responses they received. See *Appendix B* for a full description of the questionnaire.

### Data Analysis

For part one: themes of social responses, I analyzed and themed the data using a thematic analysis process in alignment with Braun and Clark's (2006) six-phase thematic analysis framework. Thematic analysis is a process for identifying, analyzing, and reporting patterns found within the data (Braun & Clarke, 2006). A thematic analysis is an adaptable and useful research tool, that can allow for a detailed account of the data (Braun & Clarke, 2006). I began the data analysis process by familiarizing myself with the raw verbal data as I transcribed them

into individual transcripts, one for each participant. Then I decided to search the entire data set for all the different social interactions and responses that were described in the interviews. Next, these specific interactions were examined and coded. Patterns in the coded data were identified and connected to the broader themes (positive and negative social responses). The next phase involved the generation of initial codes where an initial list of possible patterns/themes was compiled. In phase three, I sorted the different codes into potential themes and collated all the applicable data extracts within the identified themes. Phase four is where the themes were reviewed at the level of coded data extracts and in relation to the entire data set to ensure the accuracy of the themes. In phase five, the final themes were defined. Once I extracted the types of social responses the participants received, I moved on to part two of data analysis: contextualized responses to social responses.

In this second part of the data analysis, I used the themes identified in part one to identify the data that reflected the ways in which the participants responded to the social responses. The *Response-Based Contextual Analysis Framework* was used to investigate how participants' responded to the social responses they received in terms of the following: the context of the participants' relationships and experience of pregnancy, the social responses given in labour and the participant's responses, the participant and other social actor's responses to the cesarean, postpartum social responses received and participant's responses to them, and finally, responses to social discourse.

### Limitations

The main limitations of this study are its small sample size and that it only includes people from a limited geographic location. Therefore, the findings of this study cannot be generalized to the larger population. Another limitation is that the study participants were

comprise of white, educated, middle-class women who were in long-term relationships. It is likely the findings of this study would be quite different if the participants were from a different demographic or geographic location. Additionally, the use of an online survey may limit participants, as the use of technology can be a barrier to participation for people who lack computer skills and access to a computer.

## Chapter Four: Results

In this chapter I will provide a detailed overview of the findings from the thematic analysis and the case study analysis. In part one, the themes of the social responses provided to the participants will be presented. In part two of this chapter I will provide a detailed account of the participant's responses to the social responses they received through a case study analysis. This methodological approach offered me the opportunity to articulate the nuances of the social responses identified in part one, in a manner that justly represents the participants' accounts. Contextualizing the social interactions surrounding childbirth illuminates the manner in which women respond and make sense of their experience.

### Part One: Themes of Social Responses

The intent of this study is to better understand the relationship between having an emergency cesarean birth, and psychological wellbeing and/or harm by exploring people's experiences and perceptions within this context. Another aim of this study is to examine how people who have given birth through an emergency cesarean respond to the social responses they are given during childbirth, as well as postpartum upon disclosure of their experience. In order to identify the social responses participants were responding to, a thematic analysis was conducted exploring the types of positive and negative social responses they were given. Social responses were provided by various social actors including, medical professionals, family, friends, other community members and social discourse. From the thematic analysis, three major themes were identified as being supportive of psychological wellbeing (helpful responses): responses supporting agency, responses supporting recovery and infant bonding, and emotionally supportive responses. Responses not supportive of agency, not supportive of recovery, or were

not emotionally supportive were found to be connected to psychological stress or harm. The subthemes associated with these broader categories are also listed below (see Figure 1).

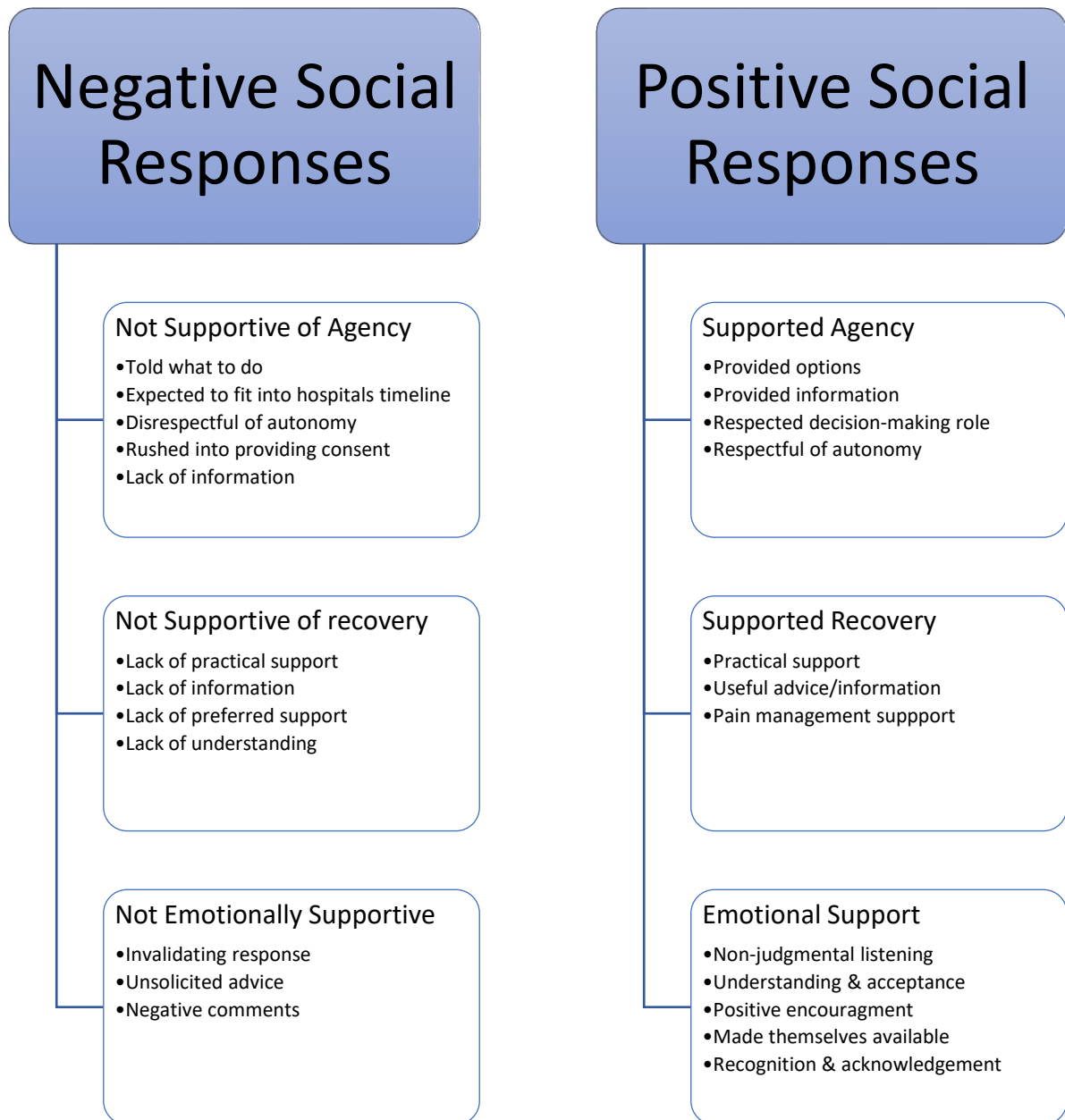


Figure 1. Themes and subthemes of social responses given during childbirth and postpartum.

Supportive of agency. The data revealed that many participants were given social responses that respected their agency. Social responses that supported participants' agency

involved the social actor supporting the participant in one or more of the following ways: providing information, providing options, respectful of autonomy, sharing useful advice/opinion and/or supported the participant's decision-making role.

***Autonomy.*** An example of a social response that supported autonomy was given to one participant by an attending nurse who encouraged her to listen to her body. This social interaction is further described in the nurse's statement as reported by the participant:

Zoe: I was also narrating out loud my thought...you know, I know that I want to get the epidural not too late, but I also don't want to get the epidural too early, because I want to be able to ambulate, I want to be able to move around...I just feel that in my bones that is what my baby wants me to do. And [the nurse] said, "you know what, if that is what your instinct is telling you to do, then do that, we will tell you if the anesthesiologist is going off call or something but why don't you try and move around for as long as possible."

This nurse encouraged the participant to trust and listen to her body which reinforced the participant's autonomy. Not only do these types of social responses foster autonomy but they also carry the presupposition that labouring people have the capacity to make decisions about what is best for themselves and their baby.

***Provided options.*** Another participant's physician and her obstetrician provided her with options as described in her statement:

Lily: They gave me three options. They said, 'do you want to keep trying to push some more, do you want to try forceps, or do you want to try a C-section?' And I chose to try forceps and then the C-section, but they gave me the choice to keep pushing some more.

Yeah, that's how it was presented to me as three options and I got to choose.

Many of the participants reported they felt like they were provided options.

*Provided information (and options).* Throughout the data participants frequently mentioned their doctor provided information to them. An example of this is highlighted in the following social interaction between a participant and her physician, who was presenting information and options to her regarding how she might like to proceed in labour:

Sam: He was like, “okay we have two options, your baby is essentially stuck, her head is too big to pass through, or is most likely too big, but you have two options, you can have a C-section, or we can use forceps. But with the forceps we can’t guarantee that the baby will still come out, and you might end up with a C-section. But you have some time to think about it.”

The information and options presented in this social response were intended to help the participant make an informed choice about how she wanted to proceed.

All of the aforementioned social responses were identified as helpful to the participants who shared them. All but one participant received social responses that were supportive of agency. All of the participants who were given this type of social response appraised their birth positively. The only participant that did not feel like the responses she received were supportive of her agency also happened to be the only participant who reported her birth as being a negative and traumatic experience.

*Not supportive of agency.* Another consistent theme in the data was that participants also reported they were given social responses that were not supportive of agency. Social responses that were not supportive of participants’ agency involved withholding information, telling participants what to do, rushing participants into providing consent or did not ask for it, disrespectful of autonomy (dismissing bodily knowledge), and expecting participants to fit into hospital/medical professional’s schedule/agenda.

*Expected to fit into hospital's schedule/agenda.* An example of a social response that expected a participant to fit into the hospital and medical professional's schedule is highlighted in the following comment provided by a participant:

Zoe: But [the medical professional] walked in that day, maybe he had already been there for 30 hours, our medical system is so fucking broken, and I think that he saw in his mind, I have this puzzle piece here, and this puzzle piece there, and I know where this woman should go, and I know what will happen with this one. He had a plan and a way he was going to organize his day and...His agenda and his judgment...

This participant reported that she was given numerous social responses similar to this example from this medical professional.

*Disrespectful of autonomy.* The same participant also shared the following example of how [a medical professional] did not respect her autonomy and neglected to seek her consent before performing a cervical exam:

Zoe: ...the first time the [medical professional] came in he didn't introduce himself or ask how I was doing, we had this lovely Zen set up in the room, the lights were dim and the music was playing, and he came in and flicked on all the lights, literally every light in the room, and then without even telling me what he was going to do, he just started doing a cervical check, so no consent, horrible bedside manner, what I would consider to be abusive.

This medical professional disregarded the participant's efforts to cultivate a safe and comforting birthing environment for herself and imposed his agenda.

***Rushed into providing consent.*** The following participant was rushed into providing consent to have an epidural before she wanted to. This social response is highlighted in her following statement:

Suzie: I had no idea, where we were or anything like that, and then I needed, I got a delivery room and got an epidural right away....I was like, oh no, let's wait....but they were like if you don't get it now you might not get it at all. I was like okay, let's get it now but then it slowed down everything.

The medical professional's awareness of the lack of available anesthesiologists likely underpinned this social response. If the participant did not take the option while it was available, there was no guarantee that she would have the option at a later point.

***Told what to do.*** Another participant reported she was given a social response from a nurse who disregarded the participant's autonomy and told her what to do (Sam): "*...Every time I would push, she kept on saying, you need to push harder....You are not pushing hard enough!*" The medical professional was trying to get the participant to do something that was against what Sam's body was telling her.

***Lack of information.*** Three of the participants shared that medical professionals did not provide enough information to prepare them for the cesarean surgery and recovery. An example of this is highlighted in one participant's description of the social interaction:

Claire: ...the doctors ...they were really good at saying we are doing this, and we are doing that, but I didn't know that the medicine would make me shake uncontrollably and I was like I am freezing and to me I was so focused on being freezing that I think I missed a lot of it because I was like... 'I'm...so....cold...' ....I think I was just so focused on that bit that even seeing [my baby] for the first time I was like, 'I'm really so cold.'

This social response came up repeatedly in the data. The lack of information about the effects of drugs used in surgery were not disclosed before surgery (or before consenting to surgery).

Supportive of recovery (and infant bonding). The data revealed that many participants were given social responses that supported their recovery from the surgical birth. Social responses that supported participant's recovery involved the social actor providing practical support, supporting pain management and providing useful advice to the participant.

**Practical support.** The social response of practical support was the type of response considered most supportive of recovery by all of the participants. An example of a social response that provided practical support is mentioned in the following participant's comment (Suzie): "...because I had a C-section and I couldn't walk around, my mom would come daily, and she would just clean the house for me while I was hanging out with the new baby..." The social actor supported the participant's need to rest and bond with her newborn.

**Supported pain management.** Any type of support that helped many of the participants manage the pain they were experiencing was identified as a supportive social response. A description of this is found in the following participant statement:

Zoe: So, the biggest thing that I think people helped us acknowledge and practically work through was the pain of having had a cesarean. I had an incredible amount of postoperative pain...So that was practically, how people responded to the fact that we had a C-section afterward, was a lot about helping us pick up medication, bringing us heating pads, just dealing with the pain and validating...yeah, all labour leaves you with a significant pain and changes to how you can move but like, fuck, having a C-section sucks.

Social responses of this type are similar to practical support but are more focused on helping the participant manage and find relief from the postoperative pain that is unique to cesarean births.

*Useful advice.* The sharing of useful advice around recovery was also found to be a helpful social response as described in the following participant's response:

Suzie: One of the things I found very helpful with the advice was uhm...actually go get a specific C-section massage to help so there wouldn't be, so the scar tissue wouldn't travel. It's stuff like that, [various medical professionals], nobody recommended anything like that.

Social responses in this form seemed to be provided by other people who had previously experienced a cesarean and learned about specific resources that are unique to the needs of postoperative recovery.

Not supportive of recovery (and infant bonding). The participants also reported they were given social responses that were not supportive of recovery. Social responses that were not supportive of participant's recovery and infant bonding involved the social actor not providing practical support, providing support that was not the type of support needed, not providing information on recovery, and were unknowledgeable about surgical recovery.

*Lack of practical support.* One participant describes a social response lacking in providing preferred and practical support in her following comment:

Lily: A [family member] showed up like two weeks later and was not really what I wanted. I wanted more space and he is very useless and didn't even put his own dishes in the dish washer or cook or grocery shop or do anything.

This type of social response places extra burden and responsibility at a time where postpartum families are adjusting to life with a newborn.

***Lack of preferred support.*** Lack of preferred type of support was also found in the data as being not supportive of recovery. An example of this is shown in the following participant's comment:

Suzie: I think it was from people who were like you should like...oh I have this donut [pillow used for recovery from vaginal births] you can sit on...and I was like I don't need a donut to sit on...luckily. I'm sorry you needed the donut but... like it's just people not understanding. It was nice for someone to offer someone a donut but uhm, yeah just, I found that there were things that people were like, well this is what I needed after I had the baby and I'm like yeah that's not what I need and uhm...

These types of responses acknowledge a need but make assumptions about what would be helpful. They are likely good intentioned but fail to understand and support the specific need of the postpartum person.

***Lack of information.*** Social responses that did not include useful information about recovery were also common in the data. An example of this type of social response is as follows:

Suzie: I will definitely say that even the crash course with the doula did not really help with what was going to happen with the cesarean. Even with just having the surgery. I never have had major surgery before, so I had no idea about anything and neither did my husband. And the funny thing is that my dad, he is the only one who had...he has had surgery twice, so he was kind of like the one person who I was like, 'hey you should know.'

The data repeatedly showed that the participants did not receive the necessary information to prepare them and their significant others for surgery and recovery.

***Lack of understanding.*** Throughout the data there were examples of social responses that demonstrated that the social actor was unknowledgeable about cesarean surgery and recovery. An example of this type of response comes from a participant whose partner struggled to understand the realities of postoperative care and recovery:

Lily: I would say my partner really didn't get the whole C-section recovery thing and I don't know if there is any question about that. He was really encouraging of me to go for long walks very quickly and kind of like getting me ready for him to go back to work....I remember within the first two weeks we like went to the [ocean] walked to the store and back and I carried [my baby] that time, which I was not in any shape to be carrying...and then went [for another] long walk which was way too much. Yeah, he just didn't get that I was recovering from major surgery...Even when I started running again he was trying to push me to go longer distances way earlier than I should.

The social actor did not provide an understanding of the physical restrictions that follow a surgical birth.

***Emotionally supportive.*** Throughout the data social responses that were emotionally supportive were identified. Social responses that emotionally supported participants involved the social actor providing non-judgmental listening, making themselves available, acknowledgement and recognition, understanding and acceptance, and positive encouragement.

***Non-judgmental listening.*** An example of a social response that provided non-judgmental listening is noted in one of the participant's following remarks (Claire): "I would say my best friend and my aunt checked in to see how I was doing more. I think they just listened to me and supported me..." Family members and friends responded by providing space for participants to debrief and process.

***Made themselves available.*** Some of the participants reported significantly helpful social responses came in the form of prompt availability, which is described in the following comment:

Rebecca: I talked to [medical professional] on the phone and she said, ‘oh we will come out to the house this afternoon,’ and she came out at least 2-3 times.... but I just felt like she really gave a shit, the fact that she was like, ‘yeah, I’m going to come out this afternoon.’

Social actors demonstrated they cared by making themselves available to participants promptly.

***Recognition and acknowledgment.*** Out of all of the social responses that supported participants emotionally, recognition and acknowledgement was frequently mentioned as an emotionally supportive response. One participant talks about this type of response in the following comment:

Lily: I had gone to this fitness class and I remember telling [the instructor], the first time I showed up, I was like okay, I’m seven weeks post C-section, I don’t know what type of core stuff I can do and just the way that she was like, ‘oh, you had a C-section, okay great, let’s talk about adaptations,’ and like, she really acknowledged it and recognized that I needed different things because of it.

Social actor’s recognition and acknowledgement of participants experience validated their needs.

***Acceptance and understanding.*** Social responses that provided acceptance and understanding were also identified in the data, and almost all of the participants mentioned they found this type of response from friends who had also had cesarean births. An example of this social interaction is identified in the following comment from one of the participants, (Suzie):  
“...it’s just nice to be able to talk to somebody about it who understood what it is like to be in

that room...the recovery, what it is like to laugh or cough...get into bed, everything...that acceptance, that knowing.”

People who had previously experienced a cesarean provided understanding.

**Positive encouragement.** Positive encouragement was also identified as a social response that was emotionally supportive. An example of such a response is described in the following remark from a participant:

Zoe: [Family member] texted and said, ‘you know [Zoe], you are so strong and how ever your baby needs to be born, your baby will be born, and it will be beautiful.’ And because he is a man of such few words, I think his text message actually was one of the most impactful because I really knew that he meant what he was saying, and it reflected back to me the truth that I already knew, which is that I am incredibly strong and how ever this needs to happen, it will happen.

Social actors provided positive words of encouragement that reflected back what participants already knew about themselves.

**Not emotionally supportive.** Participants also reported they were given social responses that did not emotionally support them. The main type of social responses identified as not being emotionally supported came in the form of: negative comments, invalidation, and unsolicited advice.

**Negative comments.** An example of a negative comment given to one of the participants is depicted in her following comment, (Suzie): “Basically anybody that you would say, ‘oh I had a C-section’ and they would be like, ‘oh, that’s too bad.’ ” This type of social response is based on the presupposition that cesarean births are a negative outcome and something to feel bad about.

**Invalidating.** Invalidating social responses were also observed throughout the data. An example of such a response is highlighted in the following disclosure from a participant:

*Zoe: One of the [medical professionals] after, in one of our postpartum visits I was saying, 'look I'm still having an incredible amount of pain....and her response was sort of like, 'well, you had a C-section' ....I remember at that point, anyone who couldn't ah, validate my pain and say things to me that were about acknowledging how painful it is to have major abdominal surgery, uhm, those comments really hurt....And so to have people sort of say to me, 'well, pain is pain, got to get through it,' those were very unhelpful. Very dismissing...*

Medical professionals dismissed and invalidated participant's experience of postoperative pain.

**Unsolicited advice.** Social responses that came in the form of unsolicited advice were also identified in the data. An example of this is highlighted in the following participant's remark (Rebecca): "Most people just don't get it. We don't expect people to understand but that unsolicited advice that is not helpful and is frustrating." Social actors who didn't understand the participant's struggle provided unhelpful and unwanted advice.

## Part Two: Contextualized Responses to Social Responses

The thematic contextual analysis was used to identify emergent themes of participant's social responses to the responses they were provided. The following case study analysis of six participants' detailed accounts of their experience having an emergency cesarean birth is used to consider the contextual factors surrounding the social responses they were provided. Moreover, analysing the participant's responses to the social responses they were given in context, is in alignment with the theoretical framework of response-based practice (RBP), which underpins this study's objectives and structure. From an RBP perspective, understanding the participant's

context is essential to understanding how they respond to labour, surgery, and the social responses (including social discourse) they are given. Furthermore, by viewing the emergent themes in the contextualized case studies, the researcher also reduces the risk of misrepresenting the participant’s experience.

An adaptation of the *Response-Based Contextual Analysis Research Framework* was used to structure the case study analysis (see Figure 2). To protect the identity of the participants they will all be referred to with pseudo names.

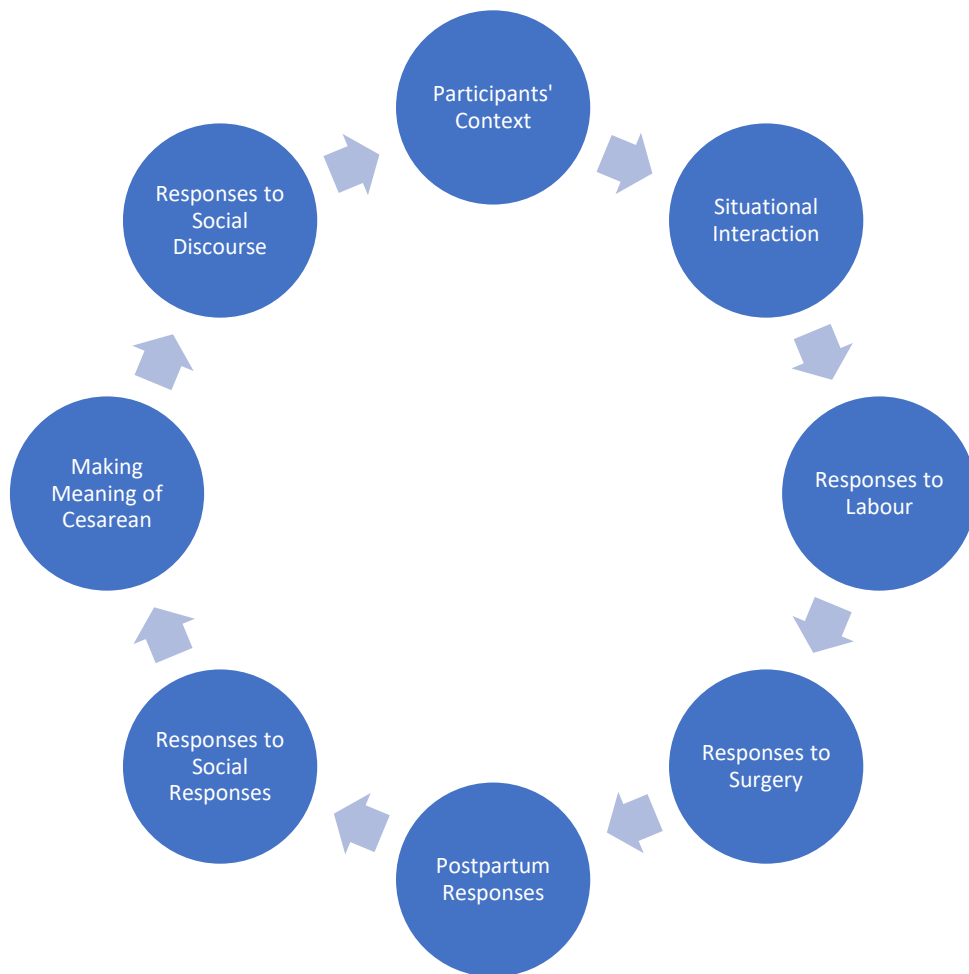


Figure 2. Adaptation of response-based contextual analysis research framework

Case #1: Sam. This case demonstrates that decisions made throughout childbirth are not made in isolation; they are social processes. Women make decisions after receiving various social and physiological responses. In this case, Sam ultimately makes her own decisions about what interventions to use, but these decisions are mediated by the various social interactions she encounters throughout labour. This case also elucidates how one unit in the social network (the mother-in-law) can put stress on the family who is already feeling the strain of adapting to life with a newborn and recovery from a surgical birth.

**Participant's context.** Sam is a white, married, educated, middle-class, 36-year-old woman. This was her first pregnancy which she and her husband planned. She described her relationship as being one of a partnership and that they make a good team. She felt well supported by her husband and her family throughout pregnancy. She had a well-established relationship with her doctor and felt supported and safe in his care. Sam reported she felt connected to her baby and was excited for the birth. She felt good emotionally throughout her pregnancy and did not have any prior history of mental health concerns.

**Situational interaction.** Sam planned for a vaginal birth at the local hospital and ended up having a cesarean birth. Throughout the labour and birth, she was attended to by various nurses, her doctor, and an obstetrician. Her husband was her main support person throughout the labour and birth, and she chose not to have any friends or family members present aside from him. Her doctor and her husband were aware that she wanted to have a vaginal birth without interventions such as an epidural. That said, she and her husband were open to the possibility that interventions, including a cesarean section, may be possibilities to consider if needed.

**Social responses given in labour and participant's response.** Various social responses were provided throughout Sam's labour leading up to the decision to have a cesarean section.

She described her labour as being “super, super painful” and found it validating when the nurses acknowledged her labour wasn’t abnormal, but it wasn’t the average to have so many contractions. She was trying to avoid having an epidural but after the doctor broke her waters the pain “skyrocketed”, and he provided information and his opinion that he didn’t think her baby was coming until many hours later. He thought the labour was going to be very difficult for her to get through:

He said, ‘You don’t have to,’ he is very good at empowering women and wants to make sure every woman makes their own choice, but he said, ‘something for you to think about is that you have a long way to go, and you are going to be very, very tired.’

At this point in labour her husband acknowledged that she didn’t want to have an epidural but also encouraged her to consider having the intervention. Sam responded by reflecting on how the pain relief medications that were attempted up to this point provided no relief from the increasing pain and made an informed decision to have an epidural which she described as being “an amazing choice.” After the fact, in sharing her story with me, she commented that she doesn’t know if it was the right choice but, in the moment, it really helped and made sense to her. In that moment, she assessed the information available to her, and her level of pain, and made a decision that made good sense to her. She trusted her doctor, because he respected her autonomy and agency, which made it easier for her to accept his influence despite her original desire to not have an epidural.

When Sam started pushing, the nurse attending her birth would tell her to push harder:

Every time I would push, she kept on saying, you need to push harder. I was like, I can’t, I am trying but I can’t...then at about two hours in, the nurse kept on saying, ‘You are not

pushing hard enough'...I was like, yes, I understand that, but I can't, and I don't know why, but I just can't push any harder.

Sam responded by resisting the nurse's instruction and listened to her own bodily knowledge instead. How Sam makes sense of her response is highlighted in her comment that, "I have a pretty strong personality and I know myself well, so I can advocate for myself." The nurse called in Sam's doctor as a response to her resistance and self-advocacy.

Sam's doctor acknowledged her difficulty pushing and suggested that a specialist's opinion was required. The participant felt relief and validated upon hearing this as she describes in the following comment:

I was like, 'yes!' I felt very validated hearing that because I knew nothing was imminently wrong, but I knew there was a reason why I couldn't push hard but I didn't know what it was. It was my body saying, 'don't push harder because it is not going to work.'

Sam felt validated when her doctor recognized that something wasn't right and called in the obstetrician. The doctor acknowledged and validated Sam's knowledge of her body, where the nurse, although trying to be helpful, was dismissive of Sam's knowledge of her body.

The doctor and obstetrician informed Sam that her baby was essentially stuck and that the baby's head was most likely too big to pass through. She was provided two options: have a cesarean section or attempt a vaginal birth with forceps. He told her there was no guarantee with the forceps that her baby would be born vaginally, and that she may still end up with a cesarean delivery. He then gave her time to think about it with her husband. Sam responded by asking her doctor, and the obstetrician, what they recommended. At which point they gave the decision-making responsibility back to her and her husband but informed her of the risks associated with

forceps and cesarean deliveries. He also told her that a C-section doesn't carry as much risks and that she could try for a vaginal birth after cesarean (vbac) with her second. Sam and her husband decided to have the cesarean section.

The doctor and obstetrician provided options and information, that helped Sam make an informed decision and promoted agency.

**Responses to cesarean.** When I asked Sam how she responded to hearing the doctor and obstetrician offer her the option to have a cesarean section or use forceps she told me she felt a sense of relief as described here: "Good. Relief, Yeah. I knew that then [baby] would come out and that [baby] would be safe.... when I was able to make that decision I was like this is what is best." After Sam made the decision to have a cesarean section "things went really scary" for her. By this point in her labour the effects of the epidural had worn off and she was experiencing "extreme pain." The medical staff were trying to get her to take a "bitter liquid" to decrease her chances of vomiting during the surgery. The participant responded to the social responses she was given in this social interaction with resistance, by refusing to do what medical staff were telling her to do. She trusted her body would reject it, knew what was best for her body and didn't let medical staff or her husband tell her otherwise.

Sam felt very scared, sick, cold, and was shaking a lot when she was on the operating table. She described the surgery as follows:

Because I was convulsing so much and I was really, really cold, I went into a bit of a blur, and then when I was in the operating room, I didn't remember this, because I was scared, because I wasn't feeling well, not because of the C-section, I was so cold and I couldn't stop shaking and so they strap you down, and I remember being like what's going to happen if I can't stop moving, is that going to be an issue when they try to get her out and

they were like, ‘no, you are fine...and my doctor was holding my hand and then all of a sudden somebody said, ‘where is her husband?’ They had forgotten to bring him in and I didn’t notice because I was so out of it.

It is clear that Sam was not provided enough information to prepare her for this aspect of surgery. She responded by feeling scared and confused. This is a consistent experience among most of the participants in this study which will be revealed later in this chapter. Furthermore, her husband responded with frustration at being ‘forgotten’ and brought into the operating room after surgery was already underway.

Sam did not get to see her baby immediately once [it] was born because they had to check her over. She depicts this as follows:

I remember not getting to see her because they had to check her over...because it wasn’t like she came out and then she got to go directly onto me. Yeah, so she was bundled up when I first touched her, and I was pretty out of it, and she was just by my head and I didn’t get to touch her. So there are pictures...uhm...I don’t think I got to hold her properly for a half hour when we were in recovery.

Social responses are embedded in medical protocol and policies. In this social interaction, medical protocol is the social response that Sam responds to with feelings of loss and delayed bonding with her newborn.

**Postpartum social responses and participant’s response.** People socially responded to Sam and her husband both positively and negatively, but mostly positively. Social responses came from medical professionals, family, friends, and other community supports.

*Provided practical support.* Sam’s family provided a lot of positive social responses in the postpartum period that supported recovery and bonding with her baby. Her husband provided

practical support which allowed her to rest and recover. An example of this is demonstrated in her following statement:

He would get up every night with me. I was obviously the one nursing but I couldn't pick her up or I would bring her out to the couch, or somewhere, and I would get stuck, like physically stuck, and so he would do all of that in the middle of the night until I was able to do more physically...

Her husband physically supported her by doing the things that she was not able to physically do herself.

Sam's mom also provided practical support by coming to her house daily to help with domestic responsibilities, which made it easier for Sam to recover and bond with her baby. Her sister provided practical support, by showing her how to use the ring sling in a way that is compatible with cesarean recovery. She also drove Sam around because she was unable to drive post-surgery for a few weeks. Furthermore, her dog walker provided free dog walks and her neighbours also helped support her recovery by walking her dog for her. Sam responded to all of the social responses that provided practical support by focusing her attention on recovery and infant bonding.

*Respectful of her feelings and needs.* Sam's family responded in ways that were respectful of her feelings and needs which made it easy for her to communicate what she needed to them. Sam's comfort in stating her needs with her family is reflected in her following comment: "My family was really, really wonderful....and it was easy to say, "I'm really tired, you have been here for an hour now, I'm exhausted and recovering from major surgery..." Sam responded by feeling at ease when she voiced her needs to her family because she trusted they would respect them.

*Shared understanding.* Sam had a few friends in her social group who also had unplanned cesarean births, which made it easy for her to talk to them about her childbirth experience and recovery. She responded with a sense of ease. She stated that the emotional aspect of the experience was “pretty easy,” because she felt understood and validated by her friends who understood what it was like to have had an operative birth.

*Lack of preferred support.* The only perceived negative social responses that Sam identified were experienced in social interactions with her mother-in-law. The social responses from the participant’s mother-in-law were not helpful and did not support recovery and bonding. When the participant stated her needs to her mother-in-law, her mother-in-law responded by dismissing her needs and requests. The following passage from Sam’s account reflects this negative social response:

She lives [out of town] so when she came when the baby was ten days old, we had said, ‘you know we don’t really want you staying in the house because it’s just a lot right now...a lot to process, a lot going on hormonally,’ I was going through a lot the first two weeks and I knew that, I expected to go through a lot of hormones....She didn’t like that and said, ‘no I want to stay because I want to bond with the baby and I think it is very important that I bond with my grand[child]’...I was like okay it’s more about us bonding...

Sam responded to this social interaction with feelings of frustration and did not feel like her needs were acknowledged or supported. Another example of a negative social response is described in Sam’s comment:

So, when she was there...She kept on taking my daughter from me and then wouldn’t want to give her back. She would be crying, and I would be like she needs to nurse, she is

hungry, and she would be like, ‘no, no, no, I’ve got this,’ and I would have to go and take her.

Sam did not feel supported by her mother-in-law and responded with resistance and by asserting herself. Furthermore, she responded with feelings of frustration and stress to the demands that her mother-in-law tried to impose on her.

**Making meaning of cesarean birth.** Sam appraises her birth experience positively and felt that overall her autonomy and agency were respected throughout the experience. She wasn’t expecting to need a cesarean birth but was open to the possibility of having one if it was required. She did not feel emotionally upset about needing a cesarean birth despite her intentions to have a vaginal birth. Sam also finds it assuring to know that the cesarean birth was the right option when she looks at photos of her baby, that confirm just how large her baby’s head was at birth. This is described further in her following comment:

And her head was big! In the pictures we were like that is a really big head! She came out in like the 25 per centile I think, except for her head which was 89<sup>th</sup> percentile....I feel better looking at photos and I’m like, whoa you really did have a big head and were not coming out naturally.

More or less, Sam has accepted the need for a surgical birth, but she also shared that she did experience a moment where she questioned whether or not she missed out on something. This questioning is highlighted in her following comment:

So, one of my other really close friends had her [baby shortly] after I did. So, she texted me quite a bit when she was in labor, and then she had a natural birth, and that was the only time...because it happened afterwards, and I was like, huh, I don’t know what that

felt like, I have no idea what it feels like to actually have a baby actually come out. There was a momentary thought there...I had no idea what it felt like...did I miss out on it? Sam made sense of this moment of questioning by considering what the outcome would have been for her and her baby had she not had access to medical technology. This processing is evident in her following thoughts:

But then I was like, you know what, I didn't, because she would not have come out and if this would have been like a hundred years ago, two hundred years ago, we probably would have both died. So yeah, I don't think I missed out.... So, there was that one moment six months later, where I was like, yeah, did I miss out...no ultimately, no, I don't think I did.

**Responses to social responses.** Overall, Sam was given mainly positive social responses which she responded to with feelings of positivity, and a positive appraisal of her birth and postpartum experience. Upon reviewing Sam's responses, to the social responses she was given, it becomes clear that her responses to specific social responses make sense when viewed in context. A visible pattern emerges from her account of her birth experience.

*Agency.* When Sam was given social responses that supported her agency, such as those that provided information and options, she responded by making informed decisions, and felt like she was in the decision-making role. On the contrary, when the social responses lacked the provision of information, she responded with fear and confusion. The relationship she had with her physician was one built on a respect for her agency and autonomy which she responded to by trusting and accepting influence from him. When she was given invalidating social responses, such as being told what to do by medical professionals, which was not congruent with what she knew to be true for her body, she responded with resistance.

*Recovery and infant bonding.* When Sam was given social responses that supported recovery and infant bonding, she responded by focusing on her recovery and baby's needs.

*Emotional Support.* When Sam was given social responses that recognized and acknowledged the pain she was experiencing she felt validated. Responses that respected her autonomy (knowledge of her body), also were responded to with feelings of validation. When she was given social responses that were respectful of her feelings and needs, she responded by feeling supported and found it easy to voice her needs. On the other hand, if she received social responses that were not respectful of her needs, then she responded with frustration, distress and resisted these social responses by asserting and advocating for herself.

Sam responded with a sense of loss and experienced delayed bonding with her infant because of social responses embedded at the macro level in hospital protocol, specifically that which requires infants to be separated from their mothers at birth instead of having the infants placed on the mother's chest right away.

*Case #2: Claire.* In this case, Claire's decision-making process reflects how her decisions are inseparable from her network of social relationships. Many of the decisions she made were mediated by past social responses she received from friends. She is one unit, in a complex social network, who is influenced by the social responses she receives from her friends and medical professionals. This case also highlights how certain medical responses (e.g. lack of information about surgical birth and recovery) can strain the individual and their entire social network throughout childbirth and postpartum.

**Participants context.** Claire is a white, educated, middle-class, 36-year-old woman. This was her first pregnancy which she and her common-law partner planned. She felt supported in her pregnancy by her common-law partner, aunt and her best friend. She described her

pregnancy as "...being easier than expected" as she thought she would hate pregnancy. She had no prior history of mental health concerns.

**Situational interaction.** Claire planned a hospital birth and had a doctor as her primary caregiver during pregnancy and birth. She was open to the possibility of needing interventions, pain medications, and a cesarean section. Claire was scheduled to have her labour induced because her doctor assessed her baby as measuring really large and there was concern about the baby growing further. Despite her desire to have a vaginal birth, she ended up having a cesarean delivery at the local hospital. Throughout her labour she was attended to by various nurses, her doctor and an obstetrician. Her spouse was also present throughout her labour and for the birth of the baby.

**Social responses given in labour and participant's response.** Claire was provided numerous social responses throughout her labour leading up to her decision to have a cesarean birth. Claire was induced which took effect about ten hours later. At which point, she experienced "super hard contractions right out of the gate." After a few hours she was told she was progressing quickly and chose to have an epidural.

Claire's baby was "sitting funny"—positioned into her hip in a way that was considered difficult for her to have a vaginal birth. After she had her epidural [a medical professional] provided Claire with the following social response:

You can go on your hands and knees to help it along, and then if you would like to, you can try giving a natural birth, but realistically you are probably going to have a C-section after that. So, you can either exhaust yourself pushing and then have a C-section or you can just have a C-section and we will give you time to weigh it...

The medical professional provided information, options, and an opinion to Claire. She accepted his influence and decisively consented to the option to have the cesarean right away.

**Social responses to cesarean.** Claire does not consider the process of making the decision to have the cesarean as stressful. When I asked Claire how she responded to hearing that she would need a cesarean birth, she shared how social responses from other people, who required cesarean births, informed her own response:

You know I don't think I over thought it, you know I think I was aware that it could always be a possibility because having friends who had also had a C-section like or like just giving birth...because they were like, 'don't make a plan because your plan is going to go horrible wrong and then you are going to be upset because your plan didn't work,' and I was like, okay! Whatever is best for me and baby, you know it's like...I was pretty much fine with that.

The decision to have a surgical birth was influenced by past social responses she received from friends who cautioned not to get overly attached to any particular outcome. Claire had mentally prepared herself for the possibility of having a cesarean section which helped her respond with acceptance. She told me that knowing that a cesarean birth was a possibility made the “C-section less of a shock.”

Although Claire appraises her birth experience as positive, she does, however, wish the doctors would have better prepared her for the experience of having a surgical birth. As previously described in this chapter, Claire was not able to focus on the birth of her baby during surgery because she was very cold and was shaking from the medicine. Her response to this lack of information is highlighted in her following comment:

I think because I am someone who likes to know what I am getting into, it would have been like nice to know, okay, you are going to shake, it is part of the medicine, it is just what it is, you know?

Her spouse also did not know why she was shaking, and was initially concerned as well, because no one prepared them for that aspect of a cesarean birth. As a response to the social response provided by medical professionals, namely, that involving a lack of information and preparation, Claire and her spouse responded with fear and confusion which interfered with Claire's ability to connect and bond with her baby at birth. This process was delayed until she was in the recovery room. Claire also resists this treatment by identifying a need for improved practice.

*Postpartum social responses and participant's response.* Most of the postpartum social responses that Claire and her spouse experienced were positive and supportive. Social responders included her spouse, family, and friends.

*Practical support.* Claire's family and close friend provided social responses that supported her recovery by providing practical support. Examples of these social responses are highlighted in her comment:

If I wasn't breast feeding, my spouse came and rocked him to sleep, and kept the house clean, and made sure I constantly had food, so I was well nourished, so I could recover and that kind of stuff. My best friend would come over and walk the dog for us so that we didn't have to physically walk the dog, you know that kind of stuff. My aunt brought food.

Claire responded to these social responses by focusing on recovery and caring for her newborn.

These types of social responses also supported her psychological well-being as she states in the

following comment that, “I needed physical support and it helped me mentally, so I wasn’t like, ‘oh the house is super messy, and it needs to be cleaned.’”

*Non-judgemental listening.* Claire’s best friend and aunt socially responded to her by providing non-judgmental listening and support. “I think they just listened to me and supported me, if they thought anything negative about C-sections they certainly didn’t say it to me.... They were just nice and supportive...” Claire responded to this social response by feeling safe enough to debrief and process concerns with them.

*Lack of information.* Claire told me the physical recovery from having a surgical birth was a lot more difficult than she expected. A major frustration she had with the medical professionals is that they did not prepare her for a cesarean birth or the recovery. She experienced social responses that involved the withholding of information. Her response to this, as previously mentioned, is that she did not feel prepared, and experienced more feelings of anxiety than she would have, if she was more informed. It was very difficult for Claire to make sense of the difficulty she was experiencing with recovery. It is interesting to note that a prior social response, one that she received from a friend who previously had a cesarean birth, influenced Claire’s perception and expectations for recovery. This is further articulated in Claire’s words:

I talked to my friend who also had a C-section, because it was a lot harder of a physical recovery than I had expected, and I remember seeing her and she was up and walking and I was like, ‘how are you doing this right now?’ and she was like, ‘you know I actually feel pretty good,’ and for me like, I couldn’t even sit on the couch...and was like how did you do this? She had one six months prior. Whenever I came over she always just seemed so well, and I was like, how? You just had major surgery, your stomach had been cut open. When I went through it I was like whoa. I would say that the downside of a C-section was

that I never knew what that pain felt like, like the recovery process, because I had never had surgery before.

The withholding of information about recovery, coupled with her perception of recovery being easy for her friend, made it difficult for Claire to understand why she was having a difficult time coping with the postoperative pain.

*Response to newborn.* The newborn is also a social responder. Claire responded to the needs of her newborn, and the unknowns of caretaking, with symptoms of what she referred to as “anxiety”. She disclosed the following to me when I asked her about her postpartum psychological response:

Like my anxiety was heightened but I don’t know if it was due to the labour. I would say it was more do to the unknown of caretaking. The situations that you can’t control, it’s like how do I deal with this, you know? But it hasn’t been unmanageable. Just a noticed heightened.

Claire responds to the uncertainty of becoming a mother of an unpredictable newborn with feelings of anxiety.

**Responses to social discourse.** While conducting the interview with Claire it became apparent that certain social discourses, acted as social responses that influenced her experience of having an emergency cesarean birth. In the following comment she describes discourse that works to devalue cesarean births:

I always feel that with having a C-section you kind of have to say that is how you gave birth, where no one says, ‘I had a vaginal birth.’ It’s like oh I had a C-section. You have to say it, like it is a step below it or something.

When I asked her what she thought informed this type of social message, she responded by telling me the following:

It just seems that whenever you read or talk to people they will say that they had a C-section. Never, just, 'here's my baby.' You know, because you didn't really...you gave birth, you grew this child and stuff, but I think because there is the assumption that it is slightly less than...oh, it was a C-section birth.

This social discourse is a social response that works to undermine, or discredit in a sense, the childbirth experience of women who give birth by cesarean section.

Claire also shared that prior to the birth of her baby, she witnessed conversations that involved people speaking negatively about cesarean births:

I definitely know people who are like, 'oh, C-sections...' I definitely heard those conversations among friends who were like...I don't know...less than...talked about negatively like, 'oh, she had to have a C-section,' and it's like well...just support them. So I was thankful that it never came up to me, but I know those thoughts exist among people I know for sure.

In the following comment, Claire speaks to a similar, but slightly different, social message she heard prior to pregnancy. "I definitely think there are people out there who think...less than [about] C-sections and stuff, or like it's the easy way. None of it is easy, either way is not easy." These social responses and social messages are prevalent in Canadian society. This social discourse depicts cesarean births as inferior to vaginal births.

**Making meaning of cesarean.** Claire appraises her birth experience positively, and feels that her agency, and her decision-making capacity were respected. She was motivated to participate in this study, because she wanted a positive cesarean birth story to be documented, as

she feels that the main focus is on the negative aspects of cesarean births. She attributes the fact that she was always open to the possibility of needing a cesarean birth to her positive experience.

**Responses to social responses.** Overall, Claire was given mainly positive social responses which she responded to with feelings of positivity and a positive appraisal of her birth and postpartum experience. Upon reviewing Claire's responses to the social responses she was given, it becomes clear that her responses to specific social responses make sense when viewed in context.

*Agency.* When she was given social responses that respected her agency she responded by accepting influence, making informed decisions and felt like she was in the decision-making role. When she was provided information throughout labour, she felt prepared and in control of her birth experience and recovery. On the contrary, when there was a lack of information or a withholding of information, she responded with fear and confusion. Bonding with her baby was delayed in response to the confused state she was in, as well as to the medical protocol. She also responded to the lack of information or a withholding of information about the possibility of a cesarean, and subsequent recovery needs with resistance, by identifying a need for improved practice and identifying the mistreatment as medical paternalism. The relationship between the participant's response of "anxiety" and "not knowing" is a theme in her story. She was less likely to respond with symptoms associated with the DSM diagnosis of anxiety when she was informed about potential unknowns. It seems she felt less symptoms of "anxiety" when she had information and knowledge about the things in her life. The postpartum "anxiety" she experienced was likely a response to the unknown of situations, a reasonable and intelligent response given the task of becoming a parent of a newborn.

*Recovery and infant bonding.* When Claire was given social responses that supported recovery and infant bonding, she responded by focusing on her recovery and baby's needs and also felt a reduction of stress and anxiety.

*Emotional support.* When she was given social responses that were emotionally supportive she felt heard and debriefed her experience.

~~*Social discourse.* Claire was given social responses that are embedded in social discourse prior and after her birth experience. She responded to social messages that operate to devalue surgical births and construct them as “the easy way,” with a sense that her experience was “less than.” She responds with resistance to this narrative and rejects both, it, and the practice of minimizing people's experiences of surgical birth.~~

*Case #3: Suzie.* In this case, both the family system, consisting of the couple dyad, and the medical system, were experiencing a lack of resources leading up to the event of childbirth. The medical system was operating over capacity, which put pressure on the medical professionals. The social responses provided to the couple by medical professionals sent the message that they were too busy to attend to Suzie, and that she needed to fit into their schedule/agenda. Suzie entered into the medical system already feeling unsupported because her preferred means of support, (her parents), were living abroad. These two under supported systems were further tested when Suzie's baby began to show signs of distress.

**Participant's context.** Suzie is a 35-year-old, white, educated, married, middle-class, woman. This was her first pregnancy, which was planned. She has a strong relationship with her parents, who were living in another country for the duration of her pregnancy. Her husband's family live close by, but she did not feel as comfortable accessing them for support as she does her own family. She was excited for the birth of her child but also found the experience “nerve

wracking.” She reported that she experienced some feelings of anxiety about the unknown of birth and the postpartum transition of becoming a parent. She felt well supported by her husband throughout the pregnancy but had an overwhelming fear of becoming sick. She was minimally supported by some friends who had children but were too busy to provide more guidance. Suzie had a midwife as her primary caregiver. She had no prior history of mental health concerns.

**Situational interaction.** Suzie planned for a vaginal birth at a local hospital and ended up having a cesarean birth. She was eight days overdue (past the baby’s due date) and had high blood pressure. Her husband and a doula were both present at her birth. Throughout her labour and the cesarean section, she was attended to by various nurses, her midwife, and an obstetrician. Prior to labour and the birth of her baby, Suzie was open to having a cesarean birth if it was deemed necessary.

**Social responses given in labour and participant’s response.** Suzie was provided many different social responses leading up to the cesarean birth of her baby. Suzie went into labour when the labour and delivery ward was busy and at capacity. As such, she was told they wanted to have her admitted into antenatal to have her induced, but there were no available rooms for her. Suzie was sent home to wait until space opened up for her to be admitted. Once admitted to the hospital, she was supposed to have her induction device removed at 24 hours, but because they were so busy, they did not have it removed until 27 hours later. Suzie describes these social responses in her following remark: “...it was weird, the labour and delivery, the prelabour part was stressful, because I’m in the hospital but they’re too busy, everyone was saying we are “busy, busy, busy.” Suzie was expected to fit into the hospital’s schedule/agenda. Suzie responded to the medical staff’s responses with stress and anxiety.

Suzie also received social responses that did not support her agency, as medical professionals withheld information needed for her to know what was happening. Medical professionals also socially responded by rushing her into providing consent. Despite her preference to wait to have an epidural until labour progressed further, they told her that if she waited any longer she may not have the option at a later point (as a result of the labour and delivery ward being at capacity and under resourced). She accepted their influence because she did not feel like she had another option. Suzie responded to this social response with confusion and felt unclear about what was happening in terms of her labour and how serious everything was. She also responded to this by accepting influence because she did not feel like she had any other option.

As Suzie's labour progressed her baby's heart rate started to drop. After the baby's heart rate dropped a third time, her hip popped, and she found it impossible to move. Despite her incapacity, the medical staff insisted she remain mobile. Suzie describes this social interaction as follows:

They were like, 'you need to roll' and I was like, 'I can't move my leg' and it was just awful...it was awful. Ah then the [obstetrician] came in and said, 'you need to have a C-section this is getting dangerous, you need to get the baby out.'

Suzie described this experience as, "...it was, definitely...probably the most traumatic moment of my life in regard to like, even if I just think about it is like flashing colours and very concerned looks from the nurses..." When I asked her how she responded to the "very concerned looks from the nurses" she told me the following:

I felt bad, I don't know if shame is the right word, but I just felt like this isn't how...like the fact that I couldn't roll that last time...they were like you need to roll and just like...it

was kinda that moment when I realized it's not just me...like they are worried about the baby and stuff... it was almost as if...I guess it was one of those first judgments before you're going to have a kid where you are just like, I'm doing this wrong....I mean I was nervous, there was anxiety, I was scared, sad, and just exhausted.

Suzie responded by blaming and judging herself. She also responded with feelings of nervousness and fear.

**Social responses to cesarean.** When I asked Suzie how she responded to hearing that she would need to have a cesarean birth she became visibly emotional and disclosed that she responded with fear and a “feeling of being done.” This is discussed further in her following comment:

I'm kind of tearing up a little thinking about this. I don't know, so much was happening that...my husband and I looked at each other and were like...this is happening...like he had tears streaming down his face and like ah, I was like, 'we have to do this.' They were like, you need this cesarean and I was like, okay fine, we have done everything we can...like everything was done. And yeah, it was scary, it was scary, I was really scared, I mean I was scared of the whole thing, not even just going in for surgery...it was almost like this weird feeling of being 'done.'

Suzie and her husband both responded with feelings of being overwhelmed, and sadness, upon hearing a cesarean section would be needed. Also notable, is her response of having a weird feeling of being “done.”

Suzie disclosed that she again felt like she did not receive the necessary information needed leading up to the cesarean surgery. She also reported that the transition into the operating

room was sudden and she was provided little time to process what was happening. This is evident in her following comment:

I'm literally signing the paper as they are wheeling me into the OR, there was not even a second and then I just remember them putting up the sheet...I just remember being like, I do not know what is happening and my arms were just like shaking on the table. Which is apparently a normal thing, but I didn't even know that for a few years. I just felt like I was along for the ride literally.

Similar to other participants, she responded to the lack of information and preparation for surgery with confusion and fear.

**Postpartum social responses and participant's response.** Suzie received a mixture of positive and negative social responses throughout the postpartum period. Social responders included her husband, family, friends, and other community supports.

*Non-judgmental listening.* Suzie ended up seeing a counsellor who provided her with social responses in the form of non-judgmental listening. Suzie responded to this support by feeling safe to debrief and process her experience with symptoms of anxiety. The counsellor helped her put her fears into perspective and to think more positively. Suzie was able to move from feeling fearful of having another child to feeling at ease about it. This is partly because of the social responses she was given from her counsellor, and partly because her parents moved back to the community.

*Understanding.* Suzie felt alone in her cesarean birth experience, but became a part of an informal support group, when a few more of her friends, and a family member, also had cesarean births. Her response to this new form of emotional support is highlighted in her following comment:

It's just nice to be able to talk to somebody about it who understood what it is like to be in that room...the recovery, what it is like to laugh or cough...get into bed, everything...that acceptance, that knowing....I wasn't really able to talk about it right away but about a year later it was a lot easier.

Suzie responded to social responses in the form of understanding and acceptance by feeling understood and validated.

*Recognition and acknowledgement.* Suzie disclosed that comments that recognized and validated her agency, instead of viewing her as a passive victim, were helpful social responses.

Suzie describes this further in her following statement:

Even some of my friends that never had a C-section or didn't even have kids...some were very supportive in a way that they didn't feel bad for me. They were just like, 'wow, that's tough, it's incredible you just had major surgery and now you have a baby.' The tone and the phrasing, they could almost say the exact same thing, but it was just...more like, wow I'm really proud of what you did and not 'oh...too bad that happened to you.'

Suzie found the social responses that acknowledged how difficult cesarean births can be very helpful as she explains in the following comment:

When people were like, wow, you just went through major surgery, that is something! When I say it out loud it sounds like I need the praise for going through surgery but just acknowledging that it is a hard thing to do and ah, but it wasn't an easy thing to do. I guess that's where I differentiate when it seems like that is the "easy" route and I'm like, it is definitely not. Like even at the time when, "you don't have to push," like you are on a metal table in an operating room, wide awake, that is different, and it is scary.

Suzie responded to these types of social responses by feeling acknowledged and validated.

Furthermore, these types of social responses counter the negative social discourse that devalues women's and people's experiences of cesarean birth, and/or the notion that cesarean births are "easy." Suzie resists this diminishing social message by contesting the notion that birth by cesarean is easy.

*Provided practical support.* Suzie reported that the practical support she received from her husband was helpful and supportive of her recovery. The following comment depicts this:

My husband was wonderful, he did most of the diaper changes, he would get her in and out of the bassinet, when she would stay in the bassinet which wasn't much. He was a huge help...I couldn't have done it by myself, that is for sure.

Suzie responded to this social response given by her husband, by focusing on her recovery needs.

Another example of a social response that provided practical support was given by Suzie's mother who travelled to Canada to help her with a lot of the practical aspects of caretaking and recovery. Suzie responded to this social response by focusing on her recovery and infant needs.

*Lack of preferred support.* Many of the social responses that she experienced were not supportive in a way that Suzie needed. Her parents lived in another country and were not around to support her as much as she would have preferred. Suzie says that she responded with symptoms of anxiety to the fact that her parents lived so far away. This anxiety manifested itself in a fear of illness, which involved Suzie responding by being hypervigilant about preventing illness in herself and her newborn. This response is highlighted in the following comment:

Lots of anxiety...came up a bit later, like I said that fear of getting sick heightened. [My baby] and I were pretty much in a bubble. If I took her to the grocery store she was in the

Ergo...on me. I wouldn't really let people touch her very much...so we kind of just kept to ourselves, but once she started solid food I got a lot of anxiety from food preparation. Anything like, I was throwing out so much chicken, I was cleaning our counters like 5 or 6 times a day...our house was literally like a hospital I would scrub all the time, and everything had to be clean. So yeah, I had a lot of anxiety.

Suzie responded to the lack of preferred support, being her parents who lived in a different country, with fear that she, or her baby, would become sick and that she would have no one to help support them. She responded to her parent's absence and her fear by taking extreme measures to protect her baby and herself from illness. Additionally, she also responded by seeking out a counsellor for support. It is interesting to observe that this participant did not actually need the support, but needed to know it was available to her, if she required it.

*Lack of support.* Another example of a lack of social response was that Suzie initially had minimal people she could talk to about her experience of having a cesarean birth. Suzie reported that most of her friends and family had vaginal births, so she didn't feel like she could talk to them about the emotional part of having a cesarean birth and couldn't relate to their vaginal birth experiences. This was a common theme in the data; many of the participants did not seek out emotional support from family and friends who had vaginal births. Suzie responded to this lack of support, by feeling alone and isolated in her experience in her early postpartum period.

*Negative comments.* Suzie received social responses in the form of negative comments about having to have a cesarean birth. Social responders made comments such as, "oh, that's too bad" or "oh, that happened." Suzie responded to these social responses with feelings of shame and embarrassment: "[I felt] a little bit of shame, a little bit of embarrassment. Because it is

something that your body is doing, right...” The participant also responded to these comments with resistance:

Generally, I just glossed over them to be honest, like I wouldn't really, sometimes I would kind of do a mindless, yeah, I'm not going to get into it. Or sometimes I would be like, 'well, that is kind of how it goes.' It depends on how much I, not prove the person wrong by any means, but kind of counter balance. Generally, if someone hadn't really been exposed to that I would be, 'well it's not the worst thing that could have happened,' and they were like, 'oh, I guess so.' I have a relatively decent sense of humor so sometimes I would try to put a funny spin on it. It's strange because if it is somebody I didn't know very well I would just be like, 'yeah, I guess so,' and just not want to get into it. But if it was somebody I knew more I would be a little more like, 'well, I have a baby and a really cool scar, and I had the full range...the spectrum of drugs that you can have and anything the hospital offers I can tell you if it's good or not!

Suzie responded in ways that she assessed as appropriate to the situation and how safe she felt with the social responder. In doing so she kept herself safe and maintained her dignity.

*Lack of information provided.* Suzie did not feel she was provided enough information to prepare her for the realities of having a cesarean birth. She reported that her crash-course with her doula and her midwives did not prepare her:

And even I would say the, I feel like the care I received from my midwives, both times, and they are lovely women, but yeah, that part you don't really...I wouldn't say it's a gloss over but that everyone is on the assumption that you're having the baby vaginally until you're not...It was strange, it was like a whole new world. You're just, the lack of,

it's almost like this won't happen...okay it happened, better figure it out and you're like, "oh, alright."

She responded with frustration and felt that she was left to figure out how to cope with postoperative pain and recovery on her own.

Another example of a social response lacking in the provision of information was given to Suzie is depicted in her following comment:

The one thing I will say about my C-section and [my baby's] birth experience is that I really wish that somebody would have told me right at the beginning, we can do all of this intervention, but the chances are you are still going to need the C-section at this point...there were so many things that were going wrong that I had no idea that they were going wrong until after...I just felt like it was almost like a class project. We are going to build a hamster maze and see where the hamster goes type thing and oh, we keep realizing they get stuck in this spot, so we will move them here. I didn't feel like I was consulted in a sense that I could make a proper decision for myself. And maybe I would have decided to keep going but I just wish I had been given that information.

The participant responded with frustration that her agency and decision-making capacity were not respected.

Suzie also felt that on top of not having been provided the information about cesarean births prior to labour she also did not feel she was provided information about why she needed to have a surgical birth:

No information on why or even with [her next pregnancy] when we were discussing the option of having the C-section my midwife was like there wasn't really a lot, everything that happened that required a C-section is kind of a one off, it's not, you're not genetically

predisposed to any of these conditions and when I was talking to the OB-GYN she was like [your last baby] was in a bad position, her cord was really narrow which was causing her fetal heart to drop, your waters were gone. There was something else and she had this list of all these things that went wrong...Even just outlining this is what happened, and this is why you needed to have C-section after the fact. It was kind of like, oh you had the baby, so you don't need to know all of this medical history.

She responded to this social response with frustration and resistance in that she recognized and identified a need for improved medical practice. This withholding of information about clients, from clients, can be considered a type of medical paternalism.

**Responses to social discourse.** The participant shared that she has observed comments in news articles about the rise of cesarean rates in Victoria and the initiatives in place to try and reduce them. She responds to this discourse in the following way:

When you see that you kind of think, “was there something else I could have done? Was there something I could have done during the pregnancy? What could I have done differently? If obviously, even the health system things we have too many of these, what are we going to do about it...and your kind of like, well, I haven't really met anyone who has gotten a C-section for a vanity reason and I feel like there is that in the back of people's minds a little bit too. About, I don't know if vanity is the right word, but kind a like “not tough enough”?

From this comment, it is clear that upon hearing these social messages, Suzie responds by questioning her experience and assessing if there was any reason to blame herself. She also perceives that there is a social message that people who cannot have a vaginal birth are “not tough enough.” This aligns with hers, and other participant's perception of society thinking that

cesarean births are the “easy way.” Suzie resists these social messages and argues that there is no easy way.

**Making meaning of cesarean birth.** Suzie has a negative appraisal of her birth experience. She does not perceive many of the social responses she was given in childbirth to be respectful of her agency and decision-making capacity. As such, she did not feel that she was in control of her birth experience and instead felt like she was “along for the ride.” She doesn’t believe there was a choice to not have a surgical birth from a safety perspective. Suzie responds to her birth experience by questioning and wondering whether she would have been able to do this herself:

I guess I will always be like, would I have been able to do this myself, if it was back in the middle ages would [my baby] and I even be here today? But then I think modern medicine is a miracle, everything worked out and it’s great, and obviously so many people are living due to different medical phenomena and not necessarily C-sections but yeah, you just kind of feel like...[this was] something I couldn’t do on my own. But then I always have to remind myself that there are lots of things that people can’t do on their own...

Suzie makes sense of her cesarean birth by appreciating the existence of medical technology. There is a tension in her narrative as she struggles to fully accept that birthing a child on her own without medical interventions is something she never got to experience. She resists this narrative by acknowledging to herself that there are many things that people are unable to do on their own. Suzie also responds to the experience by recognizing that she is now a better friend, or mom-friend, to anyone who has a cesarean birth.

**Responses to social responses.** Overall, Suzie was provided a mix of positive and negative social responses throughout childbirth and postpartum. A lack of positive and preferred responses is what stands out. She appraises her birth negatively and felt traumatized by the experience. When considering Suzie's account, it seems that she did not have the types of postpartum social supports that she needed. She also was not provided very many social responses in labor that supported her agency and decision-making capacity. Upon reviewing Suzie's responses to the social responses she was given, her responses become intelligible. A clear pattern emerges from her account of her childbirth experience.

*Agency.* When she was given social responses that did not support her agency, such as withholding of information, lack of options, and rushed into consent, she felt confused and scared. When she was told what to do and was expected to fit into the hospital/medical professional's schedule/agenda, she responded with feelings of stress and anxiety. From Suzie's account, she didn't really receive any social responses that supported her agency and autonomy. In response to not being able to "roll" and the concerned looks from the nurses, she started to judge and blame herself—"I'm doing this wrong."

*Recovery and infant bonding.* When Suzie was given social responses that supported recovery and infant bonding, such as practical support and the provision of information, she responded by focusing on her recovery, sought out treatment that supported her recovery, and was able to care for her baby. When Suzie did not receive preferred support, she responded with symptoms associated with anxiety. When Suzie was not provided information about recovery, she responded with frustration and felt like she was left to figure it out on her own. She also responded to the lack of information about the rationale for the cesarean with frustration and resistance, in that she recognized and identified a need for improved medical practice.

*Emotional support.* Suzie did not share many examples of emotional support. She responded to a lack of emotional support, by feeling like she had no one to debrief or process her experience with immediately postpartum. She felt isolated and alone. When she was given social responses that were not emotionally supportive, such as negative comments, and lack of understanding, she responded to the former with feelings of shame and embarrassment. Suzie also responded to these responses by either using humor, challenging them, or disregarding them. Suzie responded to the latter with feelings of frustration and a sense of not feeling understood.

Later she received emotional support from a counsellor who provided non-judgmental listening, which Suzie responded to by processing her experience and struggles. When Suzie found a group of women who had all experienced cesarean births, who socially responded to her with understanding and acceptance, she responded with feelings of validation and felt understood. When she was given social responses that were emotionally supportive, such as recognition and acknowledgement, she responded by feeling validated and proud.

*Case #4: Lily.* In the following case, how the participant makes sense of her birth experience is mediated by the relationship she has with her partner, social discourse on “natural” childbirth, interactions with medical professionals, and her lifelong history of involvement with the medical system. The participant’s experience of having an emergency cesarean is incongruent with the social messages she received from childbirth class and the social discourse surrounding “natural” childbirth. This case demonstrates how people’s experiences of childbirth are constructed through social interactions at the micro and macro level.

**Participant’s context.** Lily is a white, educated, middle-class heterosexual, 32-year-old woman in a common-law relationship. This was her first pregnancy which she and her spouse

planned. Lily did not feel “hugely supported” in pregnancy. She did not feel well supported by her partner as he didn’t acknowledge the work and stress involved in a high-risk pregnancy.

Lily had a doctor as her primary caregiver and felt that her doctor focused more on tests and medical care, and there were no conversations about birth care. Lily described her pregnancy as stressful because she had to be closely monitored throughout pregnancy and she felt a greater responsibility to manage her health condition. Lily had no prior history of mental health concerns.

**Situational interaction.** As mentioned above, Lily planned to have a hospital birth because her pregnancy was considered high risk. She planned to have a vaginal birth and ended up choosing to have a cesarean birth after a prolonged labour. Lily’s common-law partner and doula were her main labour support people. She was also attended to by various nurses, doctors, and an obstetrician. Everyone attending her labour was aware of her desire to try and have a vaginal birth and of her health condition. She went into premature labour at 35 weeks, making the birth of the baby a premature one.

**Social responses given in labour and participant’s response.** Various social responses to Lily’s labour were performed leading up to the decision to have a cesarean birth. She was only 34 weeks and 6 days pregnant when her waters broke which prompted her to go to the hospital as early as she did. Lily describes her labour as being really long and that she was very tired by the end. She received positive social responses in the form of positive encouragement and coaching from the nurses, as she describes in the following comment:

[My nurse] was so amazing. She was verbally coaching me through everything. It was a long labour and I was really tired in the end, and she was really just step-by-step, breath-by-breath, coaching me through and I was really thankful for her support.

The nurse provided positive encouragement to Lily and helped her get through a difficult part of the labour. Lily also felt supported by her doula:

I felt really supported, my doula was sort of, she was, I just felt like she was a good support, but she didn't like, she wasn't leading me, she wasn't the leader, she was a support and she kind of let me guide things.

The doula supported Lily's agency by letting her lead.

Lily had a social interaction with a nurse, that she responded to with doubt about whether or not she could have done more to have a vaginal birth. The nurse provided her opinion that she didn't think Lily needed to transition into the operating room yet:

One nurse was really trying to encourage me to do some standing pushing and she didn't think we needed to go and transition into the OR universe. Well, I would say in hindsight I wonder if I could have. It has definitely bred some doubt in that decision. I thought maybe if I had done some gravity positions and I really try to reassure myself, but if we couldn't get him out with forceps, it is quite possible that he wouldn't have come...He never went past my pubic bone and the OB was trying to pull him past my pubic bone and couldn't get him. So I don't know that is pretty high up.

In this passage, Lily tries to make sense of her decision and finds some *validation* in the fact that the doctor could not get the baby to come down past her pubic bone. Knowing that it was a struggle for the doctor to get her baby to pass through helps her question the nurse's opinion.

Lily's doctor and obstetrician responded to her positively by providing her with information and options that supported her agency. She told me that she was provided three options and that they gave her the choice. "It was really between me and the OB I feel to make

the decision. The OB was really great and was like you can keep pushing and I can come back.”

This social interaction will be further explained below.

**Social responses to cesarean.** When I asked Lily how she responded to hearing she would need to have a cesarean birth she responded with the following statement:

It was, you know I have thought about that a lot and actually they gave me three options. They said, do you want to keep trying to push some more, do you want to try forceps, or do you want to try a C-section? I chose to try forceps, and then the C-section, but they gave me the choice to keep pushing some more. Yeah, that’s how it was presented to me as three options and I got to choose, and he was not in distress which really helped me a lot....So that felt, I felt like I got to make that choice which I thought was great.

When I asked Lily what difference it meant to her to be able to be in the decision-making role she responded:

It made a huge difference because I never felt like, especially around the C-section, and around that moment of choosing, the doctors were leaving that decision to me and I didn’t feel any pressure in any direction....I was the one in the decision-making role, which is really different than I think a lot of the stories we are told about hospital births and interventionist births, I think a lot, I was really anticipating not having that much control and not feeling empowered to make decisions and so when, 28 hours into my labour I was still in the decision-making role, that felt really positive.

Lily responded to the fact that she was in the decision-making role throughout her birth with surprise. Her experience did not align with other birth stories she had heard prior to birth.

Lily’s comments about her experience of surgery were minimal. She told me that because she had decided to try the forceps, she was already prepped to have a cesarean section because it

is standard protocol to prep for a cesarean birth in case the forceps are unsuccessful. At a point in the attempt to use forceps, the obstetrician no longer felt comfortable and then they transitioned to a cesarean birth.

**Postpartum social responses and participant's response.** People socially responded to Lily both positively and negatively. Social responses came from her partner, family, friends, and other community supports. The following section will describe the helpful and unhelpful responses that influenced Lily's postpartum experience and her responses to them.

*Non-judgmental listening.* Lily disclosed details of her birth experience to friends who listened to her without judgment. She responded to this social response by feeling safe enough to debrief her birth experience.

*Recognition and acknowledgement.* Lily's mother and partner provided positive encouragement and acknowledgment. An example of this is demonstrated in the following comment:

I remember my other mother saying she, it is like a weird comment, something like I didn't realize how strong you were or something. I was like okay I'm glad me birthing my child revealed that for you. But that was kind of a cool comment for her to say that she was like...and she wasn't there but I guess the way my partner relayed my process in labour, so that was nice to hear.

She responded to hearing this social response by feeling validated.

*Provided practical support.* Lily's mother-in-law socially responded by providing practical support, that in turn, allowed Lily to focus on recovery and establishing breastfeeding and infant bonding. This was especially helpful because Lily experienced some challenges with breastfeeding and was spending a lot of time and energy trying to get it established.

*Lack of practical support.* As previously mentioned in part one of this chapter, the social response from Lily's father-in-law was not supportive of her recovery in that he came to visit at a time that was inconvenient for her and did not provide practical support. Lily's responded to this with frustration. This social actor added stress to the family system by not providing practical support or respecting her needs.

*Lack of understanding.* Some of the social responses provided by Lily's partner were unhelpful and were not supportive of recovery or her emotional wellbeing. Lily's partner lacked understanding about her postpartum recovery needs and did not acknowledge the unique recovery needs of cesarean births. Lily told me that she felt that he was pushing her too hard to do things that she was not physically ready for. She responded by feeling frustrated and invalidated.

**Social discourse as a social response.** The ways in which social discourse influenced Lily's childbirth experience was elucidated in my discussion with her. Social discourse on childbirth operates through childbirth education courses which influenced Lily's experience in the following ways. Childbirth education is a social construct that is meant to educate and prepare pregnant people and their partners for labour and childbirth. What is discussed, how it is discussed, who determines what is taught, contributes to the social discourse on childbirth and normalizes one way of birthing over another. Lily did not feel like the childbirth education course she took prepared her for having, and recovering, from a surgical birth. Her experience is highlighted in the following disclosure:

There was very little information about cesarean births, and I feel that most of it was about avoiding one. Definitely not [did not prepare her for a cesarean]and very little about recovery. On the topic of childbirth classes, I feel that most of it was about avoiding one

and kind of how they were the worst-case scenario, and you only want to have one if the baby is in distress, and you are doing it to save your baby's life, that kind of thing. Where I felt like with mine, I had choice, I had agency, it wasn't because the baby was in distress and so, it was really different than I expected it to be. It just didn't seem like this horrible thing.

Lily highlighted the implicit and explicit social messages that are embedded in many childbirth education courses.

**Making meaning of cesarean birth.** Lily appraises her birth positively, and attributes much of this to the fact that she felt that her autonomy was respected and that she was in control of her birth experience. Despite Lily's wish to have a vaginal birth, she felt that she made a good choice in opting for the cesarean birth. An example of the way she makes sense of this is found in the following passage:

It was like I'm 28 hours into labour, I'm fucking exhausted, I had been having the shakes for hours.... I was physically weak, and my blood sugars were just not coming down and I was in an extreme amount of pain, exhausted from being in labour so long, so yeah, it sounded like a great choice. Like it really made a lot of sense.

In Lily's meaning making process she oscillates between feeling "like it was a good choice" and a feeling that "I should have tried harder." This struggle is further defined in the following quote:

The feeling that I am left with the most is that I should have tried harder, I should have pushed longer, maybe if I had pushed longer and done some other things I could have avoided it but then it is like, well why? I tried really fucking hard, and it kind of cancelled the effort that I did put in. But it is interesting because you are left with this feeling that you didn't try hard enough to push which is kind of...and you know I do think that

without medical intervention...I mean without medical intervention he would not exist, I would have died [without medication she needs to live], I would not have procreated.

Without medical intervention he might have died in NICU, without medical intervention he might have died in utero, and I wouldn't have birthed him. So, yeah, the only reason he is alive is because...modern medicine...right?

The conflict Lily experiences within herself is palpable in this passage. Her resistance to the doubt and the notion that she should have tried harder is evident in her reference to and appreciation of medical intervention. Lily has had a lifelong relationship with medical interventions which is elucidated in her response. She has firsthand experience about the benefits of medical interventions and technology, and as such has a trust in it that others may not have.

Of interest is her comment that, "I tried really fucking hard and it kind of cancelled the effort that I did put in." The notion that having a cesarean birth cancels out all the effort she did put in relates to what some other participants noted. This is an interesting response and can inform clinical work with people who have had similar experiences. There is an opportunity to validate all the effort these people put into labour leading up to the cesarean. This must be acknowledged and validated and not minimized or dismissed.

Also, drawing particular interest is the similarity between the self-blame and doubt. "I should have done more, tried harder" is similar to that of women who have been sexually assaulted. Many also think they should have done more to protect themselves, to avoid the negative event. In the moment, their behaviour makes sense and contains situational logic. The following comment reflects this struggle in Lily's meaning making process:

It's only in hindsight do I question that decision because in the moment I did not feel like I had any more in me and it seemed like a really good choice and it has only been in

hindsight that I am like, maybe if I would have tried a little harder. In the moment I remember feeling really empowered to make the decision, it was my decision, and that was the best decision I made, you know, in that moment. And it didn't feel rushed too, I think I had a bit of time. I was like we don't have to make this decision right now, great. Lily clearly is able to see the situational logic and believes the decision she made, was the most logical response to be made in the moment.

**Responses to social responses.** Overall, the social responses Lily experienced throughout her labour were primarily positive responses. She has a positive appraisal of her experience having an emergency cesarean birth.

*Agency.* When Lily was provided social responses that supported her agency, such as, providing information, providing options, letting her lead, respecting her decision-making capacity, she responded by making informed decisions, felt supported, and felt like she was in control (decision-making role) of the birth.

When she was given a social response that provided opinions, she responded with feelings of doubt about some of the decisions she made in labour. She also responded with resistance by looking for other information and facts to validate her decision to try forceps and to have a cesarean birth. Her response to seek out validation and confirmation is her way of resisting doubt's influence and maintaining her dignity: respect for her ability to make that decision for herself.

*Recovery and infant bonding.* When Lily was provided social responses that supported her recovery, such as practical support, she responded by focusing on her recovery and infant needs. When she was given social responses that were not supportive of recovery, such as, not providing practical support or respecting her needs, she responded with frustration and felt

burdened with unwanted responsibility and was not able to focus on her recovery and infant needs. When people socially responded with a lack of understanding, she felt frustrated and not understood. These types of responses were absent in providing practical and preferred support and demonstrated a lack of understanding about the unique recovery needs involved in having a cesarean birth. She resisted these negative social responses by contesting their validity, by continuing to listen to her needs, and finding people who were able to validate and acknowledge her needs.

Lily also disclosed that she did respond to her experience of labour, birth, and postpartum with “periods of sadness” but she attributed this response to the fact that she was physically separate from her newborn while he was in the Neonatal Intensive Care Unit (NICU) because it was premature. From her description it sounds like the sadness she felt was a response to the loss and grief she felt at not being able to have skin-to-skin contact and the immediate infant bonding. This is highlighted in her following comment:

I had periods of sadness but uhm, a lot of my stuff has more to do with him being in NICU and not being close to him, that was really hard and I was okay with it at that time you just have to be okay and you kind of don't know that it could be otherwise but now every time friends...like I have friends who are pregnant and every time they give birth, you know I didn't even get skin-to-skin for almost 24 hours. That is really hard because you don't get that back and that is really hard. I wouldn't say it is depression it is just sadness and I let myself feel it, just experience it.

Lily has also responded with sadness as a response to visiting a friend who had a homebirth. The reminder of how different Lily's birth experience was brings up the feelings of loss. She also disclosed that one day when she was driving near the hospital she started crying spontaneously:

Yeah, if I drive by the hospital, I went by a while ago....and just started crying spontaneously and I was like what is this, then I was like, oh, clearly that was more traumatic than I realized. But I will say that I cry sometimes but it doesn't affect me in the day-to-day.

Viewed in context, the sadness that Lily experiences seems to fit with her experience of loss that she described.

*Emotional support.* She responded positively to the emotionally supportive social responses, such as non-judgmental listening, validation, acknowledgment, and positive encouragement, and felt supported, validated and a confirmation of her experience. When she was given social responses of non-judgmental listening, she responded by sharing her experience and processing her concerns.

*Case #5: Zoe.* The following case contains many examples of resistance and how the different social units (e.g. the participant's social network, the medical professional network) interact and call responses from each other. It is also notable in that this participant brought a lot of knowledge about the medical system into her childbirth experience which influenced how she socially interacted with other medical professionals and navigated the system.

**Participant's context.** Zoe is a white, 29-year-old, married, educated, middle-class, queer woman. She and her partner are very connected and have a supportive relationship. Her pregnancy was described as being positive overall. She felt well supported by her partner and her network of friends. Zoe disclosed that she experienced a lot of mood instability and feelings of anxiety in the third trimester. She had a midwife as her primary caregiver. She reported that she had experienced symptoms of depression in the past.

**Situational interaction.** Zoe and her partner had hoped that they would be able to have a waterbirth at home but ended up having a cesarean birth at the hospital instead. Her partner and doula were her main support people throughout the labour and birth. She was also attended to by various nurses, her midwife, and an obstetrician. Those present were aware that Zoe's preference was to have a vaginal birth. That said, she was also open to the idea of having interventions and a cesarean if it was required. She was at the hospital because her waters had ruptured without any sign of labour, and since she was GBS positive she needed to come to the hospital for antibiotics, so her midwife decided to access her at the hospital instead of at home.

**Social responses given in labour and participant's response.** Throughout Zoe's labour she experienced many positive and negative social responses. She started her labour with an awareness that a cesarean birth may be an outcome because she has had some training in the field. She reported that it was in the background from the start of her labour and became an ongoing discussion throughout it. Zoe was given numerous negative social responses from the obstetrician throughout the labour. Zoe's experience of the obstetrician was that he did not respect her autonomy and agency:

By the time he did his first cervical check in the morning sometime on Sunday he right away was like, 'we should put you in for a cesarean'... It was not giving labour a try, not seeing if my baby could be delivered vaginally because we know without a doubt that that gives the baby a head start. So what was important to me wasn't that we not have a C-section, I wasn't deathly opposed to it, but I said, Pitocin is a powerful drug, let's see if it works. He didn't want to give it a try.

The obstetrician was resistant to Zoe's choice to try to have a vaginal birth. The obstetrician told her what to do, right from the onset of their relationship. She responded by resisting his advice

and asserted and advocating for herself. The obstetrician wanted to have Zoe's midwife sign her over into his care to have the cesarean section right away. Zoe resisted this social response and she did not let his disapproval influence her. She resisted even though he was in a position of power.

One example of how the obstetrician did not respect Zoe's autonomy and agency has already been described in part one of this chapter. The obstetrician disruptively entered into the delivery room and proceeded to do a cervical exam without asking for consent. Her response to this social response is discussed in her following comment

But because I was so protective of my baby it was not an option to let his energy into my being and so I just observed that's what is happening, my partner was livid and said to the nurse afterwards, 'that was disgusting, you need to confront this guy, that was horrendous,' and so that was really playing into our feeling that our job was to sort of be friendly enough with him so that if we ended up needing a C-section that he wouldn't hate us, but be very firm with him and not let him decide things.

Zoe and her partner tolerated the treatment in order to keep Zoe and baby safe. They were intentional and strategic in how to manage him while also asserting her autonomy. This response is illustrated further in her following comment:

I knew that engaging with him would draw my attention away from what I needed to be doing....Which is also why I was like, I don't think I need to talk to this guy because I might get myself worked up to the point where I might say something that will offend him, and I don't want to offend the person who might be cutting me open in a few hours.

Zoe responded by focusing and advocating for what she needed to protect herself.

The nurse that was assigned to Zoe socially interacted with Zoe in ways that frustrated her and did not respect her autonomy. The nurse was following hospital protocol which interfered with Zoe's ability to ambulate. This interaction and Zoe's frustration are explained in the following comment:

I was very frustratingly hooked up to the fetal heart monitor constantly and even when it was happening I was like, I know this is not best practice....mainly what I remember [my nurse] and I doing is negotiating the stupid continuous fetal monitoring. When I wanted to go to the bathroom, I wanted to move up, I wanted to walk the halls, even though I had to hold my IV pole and she was the one constantly like, 'okay, but I have to put the monitor back on,' and I was like 'yes I understand! Give me a minute!'

Zoe responded to the hospital protocol and the nurse's reinforcement with frustration and negotiating the removal of it, so she could have physical mobility.

Another social response from a nurse was also reported to have been negative and disappointing by Zoe, as it did not respect her autonomy and birth preferences:

One of our frustrations with birthing in the hospital is that we had assembled the whole team of chosen family to be there with us during the labour, because something I have experienced being a part of a support team for other friends, is that you need to have people switch out...birth can be very long...hours later I said okay it's time to call so and so, so we can get these people here so that you can take a nap, and the doula can go home....And then the nurse said, 'this is not a train station.'

Zoe responded with the following (unvoiced) thoughts:

I'm thinking to myself, okay the WHO [World Health Organization] is a baby friendly initiative, like explicitly states that a labouring person should have access to their entire

support team, within reason, during the labour and process. So clearly this hospital is in the stone ages...because they had signs, 'baby friendly hospital' put up, clearly, they have not been accredited for that and they were just paying lip service to something they thought sounded good.

This unsupportive social response that Zoe perceived to be against best practices, was emotionally upsetting and required her and her partner to grieve the loss of the intentional support team they had put in place to support them throughout labour. Zoe also responded with resistance in the sense that she questioned the legitimacy of the hospital's claim that they were "a baby friendly" hospital. She and her partner responded with feelings of frustration, disappointed, and loss but made a conscious effort to take a moment to grieve and let go.

An example of how some positive social responses Zoe received from friends countered the negative social response mentioned above, is detailed in the following account from Zoe:

But the hours, in lieu of us not being able to have all of our support team cycle in and out, and in order to process that we may very well be having a C-section, my partner had text blasted our support team and said, 'this is something that might be happening, please send us messages of support,' which makes me emotional because it is just so beautiful that so many people helped us to move through that and what a blessing...

The above social interaction is an example of the ways in which Zoe and her partner resourced themselves when needed. She felt deeply validated and supported by the social messages she received from her support network. In fact, Zoe became visibly emotional when she shared this example with me.

**Social responses to cesarean.** Nearly right from the early stages of labour in the hospital Zoe and her partner were receiving social responses from the obstetrician that disregarded their

autonomy and desire to be the ones to choose when to have a cesarean. Zoe responded to these social responses with resistance and asserted her decision-making capacity and autonomy. As already indicated in this chapter, Zoe was not against having a cesarean, but she was against not giving labour a fair chance and was frustrated that the obstetrician was trying to tell her to have one right away.

Zoe did not share many details about her experience having the actually cesarean surgery with the exception of the following:

We knew labour was going to be intense, but that was a kind of intensity that was a bit different from what we had been expecting. A big part of it too, was that my epidural had worn off by the time my C-section happened. So, I felt everything, and in the moment, I was vocalizing to everyone in the room, like, I can feel your hands inside my organs, and the anesthesiologist was like, literally there is nothing I can do, like, you are open, this is what it is.

Zoe was not prepared to feel so much sensation while having surgery and responded by recognizing a need to process and debrief her experience.

**Postpartum social responses and participant's response.** Zoe was given both positive and negative social responses postpartum. Social responses came from her partner, family, friends, and other community supports.

*Recognition and acknowledgment.* Many of the positive social responses that Zoe experienced were emotionally supportive and supported recovery. Within hours after the operative birth she was visited by a friend who is a medical profession. She validated Zoe's concern that she should not have felt as much of the surgery as she did. This social response is highlighted in Zoe's account of the interaction:

I had been really validated by my friend...and I said to her afterwards, I was like, '[friend's name] was I supposed to feel everything?' Like I know it was working to a certain degree because I didn't feel the sharp pain, it was immobilizing certain pain receptors, but I felt weight more than I thought I was going to and she was like, 'oh yeah, no that definitely should not have been, it's because you had your epidural in for so long, it's not meant to happen.'

The level of validation that Zoe felt in response to her friend's emotional support highlights the value/importance that many people get from engaging in a debriefing process with an emotionally supportive person soon after their birth experience. Zoe also responded to her friend's recognition and acknowledgment with feelings of validation.

*Nonjudgmental listening, validation.* Many of Zoe's friends supported her and her partner emotionally by providing validation, nonjudgmental listening, and helped them construct a birth narrative that privileged and centered the positive aspects of their birth experience. A description of this social response is discussed in the following segment by Zoe:

They made themselves available, listened openly, nonjudgmentally, validated where it was appropriated and helped us in that labour, that work, of creating what is going to be your narrative. One friend of ours who is a therapist, and we are very close to, was particularly skillful at helping us illuminate and zoom in on the parts of the story that she could sense were the most important and most positive for us. So I know that she was skillfully helping us, tell me more about the doula. Tell me more about how you felt like you were able to decide when the C-section was going to happen and so she was helping us do the work that we were already trying to do, to lift up those positive pieces. Not to ignore the negative, but to let pieces of it go because it's not overall, not going to serve us

in moving through this so that we can now focus on the task ahead of us which is keeping this baby alive and surviving the sleep deprivation.

From Zoe's perspective, processing the difficult aspects of the birth and focusing on the positive allowed her to appraise her birth experience as a positive one. She was able to let go or grieve the difficult social responses which supported her mental wellness and allowed her to focus on recovery and becoming a parent.

*Recognition & acknowledgment; provided practical support.* As mentioned above, the physical recovery process was very difficult for Zoe, and she found the social responses that acknowledged her struggle with the pain, and responses in the form of practical support were the most helpful for her postpartum. Zoe felt validated and comforted by the support. Pain management supported recovery and validation of the pain she was experiencing supported emotional wellbeing.

*Positive encouragement, validation.* Zoe's midwives responded with positive encouragement and validation. They affirmed that she would be able to try to have a vaginal birth after cesarean (VBAC) with her second child. The following social interaction highlights this response:

I remember that one of the most impactful things they said to me in one of our postpartum visits was...I said I think I may want to carry our second child, we know we want more than one child, I really, really want to believe that a vbac is possible. Tell me the things I need to hear to know that that is possible and we had a really good discussion about optimum birth spacing and that they were able to just meet me where I was....So I think that was also very important, I think it would have also added to my, it might have made me feel more negatively about the cesarean had she not helped build me up that a vbac is

possible and it happens every day and if I do these things that can also increase my likelihood of having a vbac.

Zoe responded to the positive encouragement with hope and attributes this to one of the reasons she was able to feel positive about her birth experience.

*Validation, acknowledgment; provided information.* The naturopath that Zoe was working with provided her with social responses that were validating of her experience and struggle with pain management. The value of this social response is discussed in the following account provided by Zoe:

One really helpful response was from my naturopath, I reached out to her right away after labour...and I said to her, 'look this is what happened,' and she immediately was like I will get back to you right away, I'm going to go consult people, let's think about what different remedies we can give you to deal with this.' She was the only one that acknowledged that I was having nerve pain, that there are different types of pain.... So she, her response of problem solving about the specific type of experience I was having was immensely helpful and validating.

This social actor responded promptly to Zoe's concern. Zoe responded with feelings of validation and felt cared about by the naturopath.

*Lack of recognition & acknowledgment.* The social responses that came from Zoe's midwives were not helpful in terms of helping her manage the postoperative pain she was experiencing. In the following sentences Zoe further describes her response of frustration with the lack of acknowledgement, validation and relief she got regarding the pain she was experiencing:

All of my negative memories had to do with the pain, and feeling like, ‘hello! Is anyone going to help me with this pain?’ The system is just so not set up to help you deal with that. The reason why, emotionally, I was able to work through it [having to have a cesarean birth, instead of a vaginal one] with relative agility was that I did emotionally and mentally prepare for that possibility. So, the fact that everyone else’s total bread and butter is delivering babies and helping people after the delivery of a baby, are like, ‘oh, right, you are in pain...’ Nifty, you know. Have you not thought about this before? So that felt like a huge, wtf?

Zoe responded to the lack of recovery support and lack of acknowledgment of the pain she was experiencing with feelings of frustration.

Another example of an unhelpful social response she was given from medical professionals is discussed in the following account of this social interaction:

I was saying, ‘look I’m still having an incredible amount of pain and I’m doing everything right....and her response was sort of like, ‘well, you had a C-section’....I remember at that point, anyone who couldn’t ah, validate my pain and say things to me that were about acknowledging how painful it is to have major abdominal surgery, uhm, those comments really hurt because a big part my identity is the image I have of myself that I am a person who is very physically tough....And so to have people sort of say to me, ‘well, pain is pain, got to get through it,’ those were very unhelpful. Very dismissing and what I needed and wanted was a response that was about, ‘okay, this is the reality,’ I wanted responses that would reflect back to me what I was trying to do, which is to say, I need to accept this, that it happened but I don’t need to accept that I’m in this much pain and that my body feels completely broken.

Zoe responded to social responses that dismissed or invalidated her pain with feelings of hurt and frustration.

*Lack of validation.* Zoe disclosed her frustration with the medical staff's lack of respect and proper acknowledgement for her partner's gender identity and their sexual orientation. This negative social response is explained further in Zoe's comment:

We learned later that we were labelled on the hospital board, that we were the lesbian couple, which is totally not, my partner is trans, we are so not the lesbian couple, there is so much the medical community needs to do to learn about the experiences of queer people.

Zoe contests the hospital's lack of respect and acknowledgement of her partner's gender identity and argues that the medical professions need to learn how to work better with queer identified people.

**Social discourse as a social response.** The operation of medical paternalism and the discourse that depicts medical knowledge and professionals as proficient, and the female body as deficient stands out in this case. Throughout childbirth, Zoe consistently responds and resists much of the medical paternalism and patronizing practices that work to subjugate her bodily knowledge and sense of self. She identifies this medical paternalism and a need for improved practice.

**Making meaning of cesarean birth.** Zoe's appraisal of her birth experience is overall quite positive, despite the fact that her baby was ultimately born surgically, and not vaginally at home as intended. Zoe disclosed that she attributes the fact that she is highly educated in health care, and has experience working within the medical system, is why she was able to direct her birth as much as she did. She explains this in her following comment:

In prep for our meeting, I was trying to, what do I think lead to the fact that I view my birth story so positive is that I'm highly educated, and I'm highly educated in health care, and so I have worked with these guys, I have had to protect my patients from these guys, I've had to protect my job from these guys, and so there is so many things that play, that allowed him to not over shadow my birth experience. But for so many other people he would have completely ruined it for them, or he would have been fully trusted because of the swagger that he held when he walked into the room. So somebody else could have been like, 'oh thank god for him, without him my baby would have died.' That is the fear mongering that he was doing in there in the room, right. Well if this happens, and that happens, and we didn't go into the C-section fast enough your baby could die and I'm thinking to myself, 'you are bonkers.' A) this fearmongering is doing nothing but raising my blood pressure, which is bad for myself and my baby, so you are an idiot, and B) like there is so much evidence in front of us that my baby is fine, my baby is totally fine, and this is not what you are making it out to be.

In this disclosure, Zoe articulates that her knowledge about birth and the medical system enabled her to be able to recognize when medical professionals were not acting in her best interest, which helped her maintain her autonomy and agency throughout labour. Without this prior knowledge, she doesn't know if she would have been able to have maintained her autonomy and resisted the pressure that she perceived the obstetrician placed on her.

In the following passage Zoe offers more reasoning for her positive appraisal of her birth experience:

So how we ended up with a C-section, I guess you could say we ended up there because at the end of the day, that is how our baby needed to be born. But it was very much a, had

we not had those interpersonal capacities we would have ended up having a C-section really early on Sunday. I would have felt like my whole autonomy was taken away, I think it would have been a really negative experience, but because we had the blessing that our child was never in distress...

Here she attributes their interpersonal capacities and the fact that her baby was not in distress as factors that also contributed to a positive outcome. Zoe also considers the fact that she was open to having a cesarean birth, if needed, and the presence of her doula who had experience with hospital transfers, as significant contributors to her positive appraisal.

**Responses to social responses.** Overall, resistance is the response that stands out in Zoe's story. Throughout her account of her birth experience she identified ways in which she resisted mistreatment.

*Agency.* She responded to the unhelpful social responses directed at her from the obstetrician by asserting her intentions and resourcing herself as much as possible. Instead she privileged the opinions and information provided to her from social responders that she trusted, e.g. her midwife, partner, and circle of friends. In this case, Zoe, resisted the influence of the obstetrician's power, and identified his social responses as medical paternalistic, and asserted her right to autonomy and her decision-making capacity and agency.

Another way that Zoe responded was with mistrust about his intentions. She deliberately tolerated his responses in an intentional strategic manner that was motivated by her need to protect herself and her baby. She did this by "being nice enough that he wouldn't hate them," in case he had to perform the surgery. Zoe also responded to the obstetrician's negative social responses by intentionally minimizing his presence in the retellings of her birth story; she chose instead to center her birth story around the positive social responses she experienced. The

positive social responses, in the form of positive encouragement that Zoe received from some of the nurses, helped her respond with a feeling that her needs were recognized, and her autonomy and agency were respected.

*Recovery and infant bonding.* When Zoe was given social responses that were invalidating or dismissive of the postoperative pain she experienced, she responded with frustration and resistance. She also felt very alone with the pain and in trying to find ways to alleviate it. She identified this lack of acknowledgement as the most difficult social response to cope with, especially because she did not feel prepared for postoperative pain and recovery. Further on the topic of invalidating social responses related to the postoperative pain, Zoe responded with feeling hurt and her identity felt attacked because her struggle to cope went against the belief she holds about herself being a “person who is physically tough.”

*Emotionally supportive.* When Zoe received social responses such as positive encouragement, affirmations, recognition and acknowledgment, she responded with a sense of validation, felt cared about, and supported. She debriefed and reframed her birth narrative in response to receiving non-judgmental support from friends.

**Case #6: Rebecca.** This case presents insight into Rebecca’s experience of having an emergency cesarean while trying for a vbac. Her decision to have a vbac can be seen as an act of resistance to social and medical discourse encouraging women to elect for a cesarean birth with subsequent children.

**Participant’s context.** Rebecca is a 37-year-old, white, married, educated, middle-class, woman. The pregnancy was planned, and this was her second time giving birth. Her first pregnancy was an emergency cesarean and she was trying for a vbac for this pregnancy. She found the pregnancy physically challenging and the end of her pregnancy stressful because her

obstetrician was pressuring her to be induced. She resisted this pressure and went into labour naturally. She felt supported throughout pregnancy, especially by her midwife. Her husband was supportive, but she commented that he could have attended to her needs more. Emotionally, she experienced mood swings, anger and had a hard time coping with working fulltime and being a parent. She experienced some postpartum depression and/or anxiety in her prior pregnancy but believes this was related to the challenges she was having with breastfeeding.

**Situational interaction.** Rebecca planned a hospital birth and had a midwife as her primary care provider. Her intention was to have a vbac because she thought it was best for her baby and for breastfeeding. Despite her desire to have a vaginal birth she ended up having a cesarean delivery at the local hospital. Throughout her labour she was attended to by various nurses, her midwife and an obstetrician. Her husband and doula were also present throughout childbirth. Everyone present was aware that her intention was to have a vaginal birth. However, she was prepared to have a cesarean birth if required.

**Social responses given in labour and participant's response.** Rebecca received supportive social responses throughout labour from her support team and medical staff. She had endured a long labour and required a surgical birth when the baby's heart rate continued to drop. She reported that she felt like history was repeating itself, as labour was progressing similar to her first birth experience. Her midwife provided social responses that supported agency throughout labour, contributing to Rebecca's overall positive appraisal of her birth.

**Responses to cesarean.** Rebecca wanted to have a vbac to support her baby's health and breastfeeding. She trusted her midwife and obstetrician, and had no problem consenting to a cesarean when her baby's heart rate started to drop. She perceived there was no choice from a health perspective:

I felt like I didn't have a choice and that's okay, I didn't feel like I was getting pressured, it's just that the facts were there. I know what this is so it's not this unknown world, it's not how I want to do it, but I just want the baby to be healthy and I want me to be healthy.

Rebecca reconciled this outcome by focusing on the need to protect her baby and herself.

She also makes sense of her birth experience by reflecting on the meaning other women ascribe to their emergency cesarean births:

I know for some women, I went to this vbac support group after my first... and there was one woman there who was so angry that she had an emergency cesarean, she felt so robbed, and I was like, well...I had trouble understanding that because I'm like...for me it's all about having a healthy baby in the end.

The significance Rebecca places on hers and the baby's health mediates her appraisal of the birth.

Similar to the other participant's, Rebecca responded by engaging in a process of questioning while making meaning of her experience:

I wasn't angry about it, I just felt disappointed and then I thought, oh god, maybe I should have just gone for the elective C-section because there are not a lot of women that try for vbacs, at least it seems. Most women just go. But I don't have any, because [my baby] was healthy I don't have any regrets, like, there is always that "what if," but...

The questioning in this case had an added complexity because Rebecca was trying for a vbac. Many women do elect to have a planned cesarean with their second child which raised some doubt in her decision. Ultimately Rebecca accepts the outcome and appraises her experience positively despite her intentions for a vbac.

Yeah, I think it is disappointing but for me once it was done and it was like...there is nothing I can do about it, I can't go back in time and I can't change the outcome and I have a healthy baby and I had really good recoveries with both of my C-sections too.

Dissimilar to many of the other participants, Rebecca's experience with recovery was good and she had minimal postoperative pain. A positive recovery influences her appraisal of her experience.

**Postpartum social responses and participant's response.** Rebecca received a mixture of positive and negative social responses throughout the postpartum period. Social responders included her husband, family, friends, and other community supports.

*Understanding and acceptance.* Similar to other participants Rebecca preferred support from women who had also experienced a cesarean birth over those who had vaginal births. Rebecca also struggled with breastfeeding which complicated her situation. She found great comfort in finding another woman who shared in this struggle:

Had I not found her, I think I would have been in worse shape...way worse shape. With the C-section...I could kind of...there was enough people out there, I could reach out to those few friends, that I did have, that had C-sections but there wasn't as much opportunity for that for breastfeeding after [breast surgery]....It definitely helped!

Someone to commensurate with.

Having someone who just understood her challenges brought her relief and provided support that was difficult to find elsewhere.

*Practical support.* Social responses that supported Rebecca's and her family's tangible needs were identified as helpful: "Well there is just bringing food and just dropping it off at the

door and not coming in. I think just checking in but not prying and asking a ton of questions either.”

*Prompt responsiveness.* Rebecca found it helpful when people would make themselves available:

Public health was actually really helpful. I talked to her on the phone and she said, ‘oh we will come out to the house this afternoon,’ and [she] came out at least 2-3 times....but I just felt like she really gave a shit, the fact that she was like, ‘yeah, I’m going to come out this afternoon.’

The immediate feedback and concrete support she received validated her experience and offered practical support too.

*Lack of understanding.* Rebecca reported that she experienced a lot of misunderstanding from medical professionals, especially related to the breastfeeding challenges.

*Provided advice.* Rebecca sought out support from a well-known medical professional and responded to her advice with feelings of self-doubt:

The input made me feel shitty about myself really, it did. I totally get where [she] is coming from and I think [she] sees a lot of women who get a lot of shitty information from nurses and doctors and public health, wrong information....so that’s why [she] is so dogmatic in [her] approach but for me I felt like you just don’t understand. You are not here, you are not here in the middle of the night....and in the end I ended up not taking [her] advice and it was fine.

Rebecca ultimately responds to this social response with resistance and found a solution that worked for her. It is worth noting that because this social response came from someone who holds a lot of power and influence, she struggled more emotionally.

**Responses to social discourse.** In the childbirth community there is a lot of debate around vbac's. Many women choose to have elective cesareans with subsequent children, while others try for a vbac. The social messages that promote elective surgery over vbac's is highlighted in Rebecca's case:

People think I'm crazy when I tell them that I went through 30 hours of labour just to have another unplanned C-section but...I think people just think generally, why wouldn't you just do the elective? That is the easier way to do it kind of thing. But in my mind, I don't think that is the easier way to do it, because then it's major surgery, you know, if you are trying to avoid, I was trying to avoid major surgery again and the only way to do that was to try and have a vbac.

In the meaning-making process Rebecca recalled social messages that were supportive of elective cesareans. She responded to them with self-doubt and questioning, but ultimately felt affirmed in her decision.

**Responses to social responses.** Overall, Rebecca was provided a mix of positive and negative social responses throughout childbirth and postpartum. What stands out the most in this case is her resistance and commitment to finding solutions.

*Agency.* Rebecca's agency was supported by her midwife and the attending medical staff throughout childbirth. She responded to these social responses by trusting and putting faith in their recommendations, which in turn helped her accept their influence.

*Recovery and infant bonding.* Much of the recovery process was uncomplicated for Rebecca. It was her struggle with breastfeeding that she found most difficult. She responded to the lack of support and understanding with frustration, and resistance-by engaging in self-

advocacy. When she received responsive care from medical professionals she felt cared about and supported.

*Emotional support.* When Rebecca found another mother with a shared experience she felt accepted and understood. Rebecca reported that she experienced symptoms of anxiety as a response to the struggles she was having with breastfeeding. The lack of support, or the misguided advice, from medical professionals did not support her emotional well-being.

### Summary of Results

As identified in part one of this chapter, the main types of social responses the participants were provided can be categorized as those that are (or are not) emotionally supportive, supportive of recovery, and supportive of agency. These categories of social response can be broken down into subthemes.

The subthemes related to supporting agency include: provided options, provided information, supported decision-making role, and respectful of autonomy. The subthemes associated with *not* supporting agency include: expected to fit into hospital/medical professional's schedule/agenda, disrespectful of autonomy, told what to do, lack of information, and being rushed into providing consent.

The subthemes connected to supporting recovery include: practical support, useful advice/information, pain management support. The subthemes linked to *not* being supportive of recovery include: lack of practical support, lack of preferred support, lack of understanding, and lack of information.

Finally, the subthemes associated with being emotionally supportive include: non-judgmental listening, understanding and acceptance, positive encouragement, made themselves available, recognition and acknowledgement. Subthemes related to *not* being emotionally

supportive include: invalidating responses, unsolicited advice, negative comments, and lack of understanding. Part two of this analysis examined the participant's responses to the social responses identified in part one. A summary of these responses is provided below.

*Agency.* Most of the participants were provided social responses that supported their agency throughout childbirth. They were provided social responses that provided options, provided information and respected their decision-making role. Participants responded to these social responses by making informed decisions, felt in control, trusted and accepted influence from the social actor. The data also revealed that many of the participants were given social responses that were lacking in information. Many of the participants responded to these social responses with feelings of confusion and fear.

Participants also were provided social responses where they were expected to fit into the hospital/medical professionals schedule/agenda. These participants responded with feelings of stress and anxiety. Medical protocol and policies (e.g. continuous fetal monitoring, separation of baby and mother at birth, having an epidural earlier than desired, etc.) acted as social responses that interfered with participant's agency. The participants responded with frustration and resistance and engaged in self-advocacy and/or identified a need for improved practice. Some of them also responded with feelings of loss associated with delayed bonding.

Some of the participants were provided social responses that did not respect their autonomy, such as being told what to do. Some of the participants responded by resisting influence, engaging in self-advocacy as well as privileged and listened to their bodily knowledge over medical professional's instruction.

*Recovery and infant bonding.* All of the participants reported that they responded to the practical support they received after the birth, by focusing on their recovery and infant needs.

Some of the participants mentioned that this also supported their mental well-being because they did not have to stress about domestic responsibilities. Participants who were given social responses that did not support recovery responded with feelings of frustration and stress.

Some of the participants received social responses that provided preferred support, such as being respectful of the participant's needs. The participants who received this type of social response, responded by feeling supported and felt safe to communicate their needs. Some of the participants who did not receive preferred support or help in the way they needed, responded with feelings of anxiousness, distress, and frustration. Many of them also responded with resistance by asserting self/needs.

Some participants received social responses that provided helpful advice and responded by integrating the advice into their recovery, which in turn, improved their recovery. Many of the participants were given social responses that were lacking in information about recovery and pain management. Participants responded with feelings of frustration, did not feel prepared, felt left to figure it out on their own and resisted by identifying a need for improved practice.

Many of the participants were given social responses that were lacking in understanding about the nature of cesarean birth and recovery. These participants responded with feelings of invalidation, frustration, did not feel understood, and some felt hurt.

*Emotionally support.* Social responses that were emotionally supportive were frequently mentioned in the data. Two specific social responses stand out as being particularly useful for participants: recognition and acknowledgement, and non-judgmental listening. Participants frequently responded with feelings of validation to social responses that recognized and acknowledged their experience. Participants responded to non-judgmental listening by feeling safe enough to debrief and process their birth experience and their concerns. One participant

reported that she did not have people she could process and debrief with and responded by feeling isolated and alone in her postpartum struggle. She, like many of the participants, did not feel comfortable talking about her cesarean and recovery experience with women who had vaginal births.

Social responses in the form of understanding and acceptance were received by many participants from people who had also had a cesarean birth. The participants responded by feeling understood, accepted, and validated.

Some of the participants received social responses that provided responsive care. These participants responded by feeling genuinely cared about by the social actor, which was immensely validating for them. Positive encouragement was also mentioned frequently and was responded to with feelings of being supported. Participants reported they also were given social responses in the form of negative comments, which they responded to in various ways, but most always with resistance.

## Chapter Five: Discussion

The purpose of this qualitative study was to examine the social responses provided to women who have experienced an emergency cesarean birth, and how these women respond to the social responses they are provided. Another aim of this study was to explore what the relationship is between the social responses provided and psychological wellbeing or harm. Put another way, the study aimed to identify the types of social responses that support psychological wellbeing and those related to psychological stress/harm. People who experience emergency cesarean births respond in a variety of ways that are worthy of recognition. A qualitative thematic analysis and case studies were used to better understand how professionals can support them.

In this chapter I will discuss the findings that relate to the social responses the participants were provided from medical professionals, partners, family, friends, other community members, and the social discourse that surrounds childbirth within the Canadian context. The participant's responses to these social responses will also be examined. My interpretation of the findings will be followed by a review of my research process, the implications, limitations, and recommendations of the study. The chapter will end with my concluding remarks.

The findings of this study show that the main types of social responses the participants were, or were not, provided throughout childbirth and postpartum, predominantly fall into the following three areas: supportive of agency, supportive of recovery, and emotionally supportive. Upon analyzing the ways women responded to these social responses, an unexpected insight occurred in the observation that many of the ways in which women respond to childbirth is mediated by the social responses they are provided. Much of the decision and meaning making

process is mediated by a web of social interactions. A contextual analysis of the participant's responses revealed how childbirth is as much of a social process as it is a physiological one. Birth does not occur in isolation within the female body and is instead influenced by a collection of various social interactions and responses. For example, the notion of agency within a medical system, childbirth in this context, is a process that is influenced by relationships involving various social agents and networks. Notions of agency and autonomy within the context of a medicalized childbirth are tenuous and complicated. The capacity of labouring people to act independently is questionable, because the decision-making process in childbirth is mediated by various social agents and medical policies that interact with the labouring woman. Agency is not just something that exists or does not exist within an individual. It is constructed through social interactions.

A presupposition in response-based practice is that people always have agency (Wade, 1999). I've come to understand this as people always have agency, in the sense that as long as we are living we are responding to our environment, much like an ecosystem is always responding to the other elements or units of existence within it. "The impulse to call for responses from others and the complementary impulse to provide responses to others is basic to the human condition" (Coates & Wade, 2015, p. 178). However, labouring women may always have agency, in that they always have some capacity to act (or respond); but the amount of capacity (or agency) is directly related to the social world as agency is mediated by external relationships and social structures that surround childbirth.

The concept of autonomy is also complicated within the context of childbirth as a woman's right to act autonomously is impacted by the competing interests of medical professional's responsibility to ensure the safety of the infant and mother. The legal obligations

of medical professionals constrain the labouring person's rights to act freely and independently. Maintaining a sense of agency and autonomy in a medical context is not always an easy thing to do, as there are many nuanced influences at work that can undermine patients right to make decisions for themselves.

Drawing from the literature, Hunter (2006) points out that the medicalization of childbirth has its roots in the historical notion that doctors, and medical knowledge are proficient, while patients, particularly female patients and woman's bodies, are deficient. From this perspective, women's bodies are objectified, and the emotional and social aspects of birth are made invisible. In the current study, it became clear that within the medical system there is a shift away from this thinking, and efforts are being taken to promote women's agency and autonomy. Yet the roots of this paternalizing way of viewing female bodies still hold firm and were evident in many of the social responses the participants were given. There is an element of control that limits patient's autonomy, in that it is almost impossible to make independent choices, as the options presented are within the confines of the medical context that has to maintain policies and protocol in effort to minimize risk.

### Social Responses

The current study found social responses that promote agency involve the social actor: providing information, providing options, respecting the women's autonomy, and decision-making role. Social responses that did not promote agency include: lack of information, expected to fit into hospital/medical professionals' schedule/agenda, and disrespectful of autonomy.

*Agency.* Agency is a topic frequently discussed throughout the literature on childbirth (Soet, Brack, & Dilorio, 2003; Beck, 2015; Boorman, Devilly, Gamble, Creedy, & Fenwick, 2014). Within this body of literature, there is support, to suggest that social responses that are not

supportive of agency in childbirth, are associated with psychological and emotional distress (Soet, et al., 2003; Beck, 2015; Boorman et al., 2014). The opposite of this is also true, in that women who receive positive social responses are more likely to respond with psychological wellness (Soet, et al., 2003; Beck, 2015; Boorman et al., 2014) and a sense of dignity, as dignity has been found to be associated with the provision of positive social responses (Richardson & Bonnah, 2015).

**Providing information.** The provision of information is a key component in supporting agency and decision-making in childbirth. Without the necessary and pertinent information, women are not able to make truly informed decisions. The whole notion of informed consent becomes redundant if pregnant and labouring people are not provided the pertinent information required to make a truly informed decision. Labouring peoples' agency is related to the source and amount of information known to them about the decisions they are making. Social responses that work to increase the labouring person's understanding about the cesarean process strengthen their capacity to act (Van Reenen & Van Rensburg, 2014; Jay, 2008; Nilsson & Lundgren, 2009). The provision of information is a way that we can provide people with the information needed to assess the situation at hand for themselves. Decisions may be made, but if the person had more or different information then perhaps they may have responded differently.

For the women in this study, the provision of information was associated with positive appraisals of their birth experiences. This finding is consistent with other studies (Hauck, Fenwick, Downie, & Butt, 2007) where the participants reported a more positive appraisal of their birth experience when they were provided information, despite previously held expectations for a vaginal birth. All but one of the participants was provided with ongoing information about the birth process throughout childbirth. These participants felt they were in the decision-making

role and in control of their birth. However, it is notable that, all except one participant, reported they did not feel they were provided enough information to prepare them for the experience of surgical birth and/or recovery. Although most of them appraised their overall experience positively, they all had an aspect of their experience (e.g. surgery itself, or recovery) that they assessed negatively because they lacked the necessary information to prepare them. Drawing from the literature review, we know that women who are informed and prepared for surgical births and recovery before they are faced with the event, experience enhanced sense of preparedness and emotional well-being after a surgical birth (Van Reenen & Van Rensburg, 2014; Jay, 2008; Nilsson & Lundgren, 2009). In the current study, the negative social response of withholding information was frequently noted as a barrier to understanding the surgical process and the realities of postoperative pain and recovery. All of this suggests that medical professionals and childbirth educators need to do a better job of informing, and preparing pregnant people and their families, for the possibility of a surgical birth and recovery.

The provision of information post-cesarean about the reasons for surgery was also emphasized by some of the participants. A study by Van Reenen and Van Rensburg (2014) found that participants stressed the “need to discuss the circumstances surrounding their birth experience afterwards and to have their questions answered” (p. 674). This finding is in line with the current study in that a participant reported that she did not receive any information or have a post-cesarean conversation with her medical caregiver about why she needed a cesarean. Women are better able to make sense of their birth experiences when they are fully informed about the rationale for a surgical birth. This is another example of how the meaning making process is interconnected to the social responses women either receive or don’t receive.

*Decision-making role.* Decision-making is relational and involves a dialectical process between labouring women and their care team (Cook & Loomis, 2012). This relationship has “the potential to mediate their perceptions, especially where expectations were not achieved” (Hauck et al, 2007). Relationships with medical professionals, and the social responses women receive from them, are instrumental in determining (how women will respond to childbirth) the psychological outcomes after childbirth (Boorman et al., 2014). Women make decisions in childbirth by drawing on past social responses they received from family, friends, and childbirth courses about childbirth. Decision-making is also influenced by the relationship with medical professionals. Women were more likely to accept influence from medical professionals they trusted.

Within the literature, a study by Van Reenen and Van Rensburg (2014) found that women who were prepared, informed, and actively made decisions had a positive sense of self and felt more in control throughout childbirth. In line with this literature, the findings from the current study demonstrate a relationship between the provision of social responses that encourage agency and decision-making, and the perception that the participant was in control throughout the birth process.

In the current study, many of the participants reported receiving social responses that provided options. The provision of options typically accompanied the provision of information, both of which were provided in support of the client’s decision-making capacity. It frequently was mentioned in the data by women that they were happy they were provided options about pain management, positions for labour, and/or operative interventions. The provision of options relates to agency, in that it sends a message that the labouring person has the capacity to make a choice for themselves.

Social responses that are not respectful of women's agency and autonomy are most often met with resistance from women. Some of the women in this study were 'told what to do' by medical professionals. Most often these instructions were not congruent with their bodily knowledge. This type of response infringes on labouring women's agency and autonomy. These women most often resisted by asserting their autonomy and refusing to partake in what was being asked. When women are expected to fit into the hospitals and medical professional's schedule their decision-making role is not being respected. Nor is this practice in alignment with true consent, because women are not presented with any other option.

Responses as pathology or resistance. Some of the ways women responded to the negative social responses they were provided with can be perceived and misrepresented as pathology. Much of the existing research looks at the way women and child birthing people are affected or impacted by the 'negative social responses.' It is reasoned that the impact of these negative social responses leads to negative psychological outcomes such as anxiety, depression, and PTSD (Soet, Brack, & Dilorio, 2003; Gamble & Creedy, 2009; Ryding et al. 1998; Yokote, 2008; Van Reenen & Van Rensburg, 2015; Sharp, 2018). Similar to the aforementioned studies, some of the findings in the current study may suggest that participants respond in ways that are consistent with symptoms of anxiety, depression, and PTSD. Without considering the broader context, these responses may be interpreted as pathology. It is when the symptoms are viewed in context and connected back to the social responses the participants were given that the behaviour/response makes sense and becomes understandable (A. Wade, personal communication, February 17, 2018). However, there is no simple 'cause and effect'; for example, if A happens (the cause), then B will happen (effect) as it relates to psychological outcomes of people who experience childbirth. Childbirth is complex and far too nuanced to

extrapolate specific responses from women and cast them as an effect of an emergency cesarean birth. In the literature, a lack of support for women's agency was identified as a predictor of PTSD (Soet et al., 2003). However, it's not as simple as 'her agency wasn't respected', therefore she may be at risk of having birth trauma. Maybe, but maybe not. Furthermore, a web of social interactions influences women's responses to the social responses they are given. The manner in which women respond to social responses that do not support their agency is similar in some ways, but the exact responses differ and are related to the level of agency and social support women have. Their responses are dependent on the type and quality of social response they have been provided. Some women may outwardly resist this mistreatment and assert their autonomy, where others may silently resist. Drawing from the participants in this study, the participant who had experience advocating for others accessing the medical system felt comfortable directly challenging mistreatment and sought out the information she needed to make decisions about how she wanted birth to progress. What is interesting about this participant is that she was at the center of a web of supportive social responses. She was able to respond to the mistreatment and abuse she was given from a medical professional by resourcing herself from other sources. She was able to do this because she was supported by a large network of friends and family. Another person in the same situation, but who is not as well supported, may not be able to respond in this way.

*Recovery.* Social responses related to recovery and infant bonding were identified as important responses by the participants. Social responses that supported recovery included the provision of the following: practical support, pain management support, and useful information/advice. Social responses that were not supportive of recovery included: lack of practical support, lack of preferred support, lack of information, and lack of understanding. The

provision of practical support after childbirth and emergency cesareans has previously been documented as a helpful social response and is related to psychological wellbeing in postpartum women (Van Reenen & Van Rensburg, 2015). Consistent with these findings, all of the participants in this study reported receiving and benefiting from practical support.

The provision of useful information and/or advice about recovery care was considered helpful to many of the participants. Most often this type of advice came from people who had also experienced a cesarean birth or another type of surgical operation. The majority of the participants did not receive information from their primary caregivers or other medical professionals about how to manage the postoperative pain. As such, they felt like they were left on their own to figure out how to recover while also adapting to life with a newborn and trying to establish breastfeeding.

Support with pain management was immensely valued by many of the participants. Many of the women in the study reported they struggled with postoperative pain while trying to care for a newborn at the same time. Social responses that helped women manage the pain, e.g. bringing heating pads, sling adaptations to accommodate incision site, picking up medications etc., were helpful, and also validated mother's struggle with the pain. This is similar to findings from another study that found "that postoperative pain is a highly frequent experience among women submitted to cesarean section. The intensity of its manifestations is clinically unacceptable, that is, it can cause harm to mother and child in the immediate postoperative period" (Borges, Silva, Pedroso, Silva, Tatagiba, & Pereira, 2017, p. 381). Clearly, recovering from a surgical birth puts an additional strain on the mother and family.

Some of the participants reported that medical professionals were not responsive to their disclosure of their struggle to cope with the pain. This finding is consistent with other research

on trauma, that found that trauma survivors were provided negative social reactions that perceived or underestimated the severity of the adverse event or they lacked understanding of the negative consequences of the event (Schumm, et al., 2014). These responses are similar to responses participants were given that underestimated their experience of postoperative recovery. Postoperative recovery is a challenge after most surgeries but is further complicated for those who also have to care for a newborn after having abdominal surgery. Some of the participants perceived their caregivers were not prepared or informed enough about how to help them deal with the pain and recovery. This sense of feeling alone to figure it out was a common experience among the mothers. One of the participants reported that it felt like her caregivers were under the assumption that she was having a vaginal birth, until she wasn't, at which point she felt alone in having to figure out how to manage.

A lack of understanding about cesarean births and the recovery process was commonly reported by participants. They reported that various family members and friends did not understand what they were going through in terms of recovery. Some spouses pushed participants beyond their limits in terms of their physical capacity. Medical professionals were dismissive of the pain participants felt. Some social responses acknowledged a need, but failed to meet it, as the support they offered was based on their own assumption about what the person required, and not on what the participant actually needed.

The importance of contextualizing and elucidating women's responses should not be underestimated. Without context, women's responses to social responses that do not support recovery can be misrepresented as symptomology. For instance, by not prioritizing a postoperative pain management and recovery protocol for women, medical professionals are implicitly sending the message that the pain is not significant enough to be bothered with. Which

in turn, women may respond to with direct challenges to their sense of self and identity, as in the case of the one participant whom identified as being a strong person and found the medical professional's dismissal of her pain hurtful. Furthermore, dismissing, underestimating, and invalidating women's postoperative pain, can send the message that she is weak, or making a fuss, or overexaggerating. Women's responses are at risk of being misrepresented as "poor coping strategies or skills" or other types of pathology when in fact her responses make perfect sense when viewed in context.

The participants' recovery experiences demonstrate the ways in which the recovery and postpartum transition to motherhood/parenthood, is influenced by the social responses they receive or do not receive. Women are situated in a complex maternal health system and a social response in one area (e.g. medical professional's failure to prepare women for surgical birth and recovery) is felt within her social network in the postpartum period. These findings suggest a need to better prepare women and their social networks for the realities of having a cesarean birth and recovering while caring for a newborn.

**Emotional support.** Social responses related to emotional support were acknowledged as significant responses by the participants. Social responses that were emotionally supportive included: non-judgmental listening, recognition and acknowledgement, positive encouragement, acceptance and understanding and responsive availability. Social responses that were not emotionally supportive included: negative comments, invalidation comments, and unsolicited advice.

***Non-judgemental listening.*** Non-judgmental listening is a social response considered essential in helping women debrief and process their birth experience and related concerns (Johnston-Robledo & Barnack, 2004). Debriefing conversations with primary care providers

have been identified as being emotionally supportive. Drawing from the literature, a woman's appraisal of her birth experience can be greatly improved if she has the opportunity to debrief the birth experience with her care provider, where the reasons for the emergency cesarean can be further explained to, and understood by, the patient (Johnston-Robledo & Barnack, 2004). If a woman's questions and concerns are dismissed or met with defensiveness, then this can contribute to the development of a negative appraisal of the birth experience and negative psychological outcomes (Johnston-Robledo & Barnack, 2004). In line with this, one participant in the current study reported that she doesn't believe she would have been able to appraise her birth so positively if she did not have a post-cesarean conversation with her care provider about the reasons for a surgical birth and the possibility of having a vbac in the future.

Family and friends were also a common source of emotional support. All, but one of the participants in this study felt comfortable debriefing to people in their social network. The one participant that did not have anyone she felt she could talk to felt isolated and alone but sought out counselling for support. One of the participants found disclosing and debriefing to friends particularly useful in helping her make sense of her birth experience and in reframing her birth narrative into one that centered around the positive aspects.

The findings from this study support previous research that emphasizes the importance of debriefing women postpartum. Previous research found an association between disclosing and receiving positive social responses and less severity of trauma symptoms (Pennebaker, Kiecolt-Glaser & Glaser, 1988). Postpartum women may benefit from disclosing to someone that can listen to them without judgment.

***Recognition and acknowledgement.*** Social responses that provided recognition and acknowledgement were deeply appreciated and responded to with feelings of validation by all of

the participants in the study. Throughout labour and postpartum, people found great relief in having their birth experience, their body awareness, their experience of pain, etc. recognized and acknowledged. Many of the participants also felt proud and supported when others would recognize and acknowledge their strength and the achievement of having a surgical birth and caring for an infant. Closely related to this type of social response is that of responsive availability. Participants reported they felt that social agents really cared about them when they made a prompt effort to help. The value and importance of these types of social responses from maternal health practitioners should not be underestimated, as this type of support was found to be immensely helpful to women in this study.

*Acceptance and understanding.* Almost all of the participants found value in social responses that provided acceptance and understanding. They responded by feeling understood, accepted, and validated. Especially notable is that participants sought out this type of support from other people who had experienced a cesarean birth. They intentionally did not approach family or friends who had vaginal births for this type of support. This is similar to previous research that found that sexual assault victims received the most support from other friends who also had experience that type of trauma (Lorenz et al, 2018). This suggests that it is important to make sure that women are connected to other people or support groups who have also experienced a surgical birth. Moreover, it also furthers the argument that partners and family members should become more educated and knowledgeable about the realities of cesarean births and recovery.

As already mentioned in this chapter, when viewing the participant responses to emotionally supportive or not emotionally supportive social responses through a response-based lens, the situational logic of the social interaction becomes clear and the response becomes

understandable and intelligent. The emotional landscape of postpartum people is inseparable from the social relationships and discourse they interact with. The postpartum period is a time of adjustment for anyone who goes through childbirth and has a newborn, but the level of adjustment is increased for people who have had a surgical birth. The need for emotionally supportive responses is of paramount importance in helping women transition into motherhood.

### Social and Medical Discourse

A means to understanding the context in which people experience cesarean births is to assess the influence of social and medical discourse on their experience. Social discourse informs perceptions about childbirth and emergency cesarean births and is reflected in social responses and interactions. The women in this study observed that the social discourse on childbirth was reflected in societal attitudes about cesarean births, in childbirth education courses and in medical discourse. The devaluation of cesarean births was reflected in societal attitudes that undermine or discredit the childbirth experience of women who give birth by cesarean section. Some of the women in this study observed an implicit social messaging that cesarean births are inferior to vaginal births, and that cesarean births are the “easy way,” and that women who have them are not “tough enough.” Many of the participants reported that the childbirth education they were provided did not prepare them for surgical birth and recovery. They felt the emphasis was more about ‘how to avoid a C-section.’ Another explicit message they received was that cesarean births are bad and to be avoided at all costs. This type of messaging does not support women’s autonomy in cases when they end up consenting to a surgical birth.

Medical discourse works to undermine the female body’s ability to bear children, and is reflected in medical policies, protocols and the education of medical professionals. By viewing birth as a risky medical condition, women are subjected to various assessments and

measurements throughout labour, e.g. continuous fetal heart monitoring, vaginal exams to measure dilation etc., all of which interfere with the physiological birthing process (Buckley, 2015). Many of these macro level policies and practices may be interfering with natural birth processes and the body's ability to birth vaginally. It is concerning that many women in the study questioned why they were not able to birth vaginally and some even blamed themselves. What if some of these labours that "fail to progress" are simply the bodies way of resisting medical interruptions? Could it be that women are internalizing their bodies' resistance to an overly medicalized and disruptive setting as a failure of their bodies? If this is the case, then many women are experiencing emotional and physical distress unnecessarily.

The operation of medical paternalism and the discourse that depicts medical knowledge and professionals as proficient, and the female body as deficient, was identified by some of the participants in this study. These patronizing practices worked to subjugate their bodily knowledge and sense of self. In all the cases where this existed the women ultimately resisted this mistreatment. Many surgical births are absolutely necessary and medical technology has a role to play when needed. In fact, most of the participants identified a medical reason that necessitated the need for a cesarean. In these cases, medical knowledge and expertise is invaluable.

### Making Meaning of Cesarean Birth

Prior research on women's experience of having an emergency cesarean birth found that women who had surgical births were more likely to have fewer positive feelings overall about their birth experience (Kjerulff & Brubaker, 2018). They were more likely "...to feel disappointed and like a failure in comparison to women who had spontaneous vaginal delivery; and less likely to feel extremely or quite a bit proud of themselves" (Kjerulff & Brubaker, 2018,

p. 6). They also found that birth by cesarean negatively affects women's self-esteem (Kjerulff & Brubaker, 2018). However, in the present study almost all of the women came through childbirth with their self-esteem intact and appraised their birth experience positively. While making sense of their birth experiences, most of the women in this study attributed their positive appraisal of their birth experience to receiving social responses that were respectful of their autonomy and agency. A notable observation from this study is that some of the women were motivated to participate because they wanted to share a positive cesarean birth story. This act in itself appears to be a form of resistance. These women are taking a stand against the social discourse that depicts cesareans unfavourably, and the narrative that cesarean births are traumatizing. The women in this study were intentional about identifying the reasons why they were able to appraise their birth positively.

A sense of loss came up for women when they socially interacted with friends who recently had a vaginal birth. Friends' vaginal birth experiences presented as a reminder that they never experienced what it was like to have a vaginal birth. This demonstrates that the meaning making process is social and ongoing.

Doubt and questioning were a common postpartum response of women who wondered if there was more they could have done to have a vaginal birth. These women question themselves: "I should have tried harder;" "maybe there is something else I could have done." These responses are reflective of how women respond after assessing what meaning others ascribe to their experience. Examples of some of the meaning others ascribed to the situation are comments such as, "push harder," or "you don't need to go to the operating room universe yet." These comments bred doubt into some of the participants decisions.

Women also reported feeling a sense that the effort they put in was disqualified, almost like it was all for nothing. They described experiencing a sense of being done. Transitioning to a surgical birth requires a disconnection from the physiological aspect of birth, a disconnection from the birth process, a letting go. These responses are an invitation for medical professionals to consider how they can better promote a sense of agency in surgical births.

As already mentioned, women do not make meaning out of their experience of cesarean births in isolation. The meaning making process is inherently social and mediated by the meaning other social responders convey to women about cesarean births. Women assess how to respond after considering the meaning others ascribe to their experience. Childbirth is a nuanced process involving many social interactions and much meaning making occurs on the micro level within the institutionalized macro system.

### Experience of the Research Process

As the researcher for this study I believe it is important to disclose that I entered into this research process with my own presuppositions about childbirth. Personally, I have never had a surgical birth but have attended somewhere between 10-15 of them. My personal beliefs about the female body's ability to birth children falls into the 'natural birth' camp and I am concerned that childbirth has become overly medicalized. In my work as a doula, I have become quite concerned with the increasing rates of surgical births in the region. However, many of my previously held beliefs about childbirth, and cesareans in particular, have been complicated as a response to this study.

Using a response-based framework to contextualize the participants experiences provided me with the opportunity to gain a better understanding of the ways in which women respond to surgical births. While conducting the interviews, I developed insight about how social discourse

on childbirth operates through me. As I listened to the participants detailed accounts of their experience, and the negative social responses they were given, I realized that I'm guilty of also partaking in some of the unhelpful behaviours they identified. I felt a great tension while hearing them inform me that they did not seek out support from people who only had vaginal births, as I have had three vaginal births. I too fall into the category of people who lack understanding about the realities of a cesarean birth.

As mentioned throughout this study, people's experiences of having a cesarean birth are influenced by their social relationships. As a doula and a maternal health counsellor it is of paramount importance that I remain mindful of the ways in which I socially respond to the women I support, particularly after they experience an unintended outcome. The contextualized analysis involved in this study also gave me an appreciation and understanding about how complex and interconnected the maternal health system is. The individual units within the system can seem very removed from each other, yet what happens in one area inevitably calls for a response from the other units within the system. To improve maternal health and women's experiences of childbirth an understanding of the system as a whole is required.

I feel very honored to have had the opportunity to bear witness to the participants' experiences and the beautiful and intelligent ways they responded to having an emergency cesarean, despite having intentions to have a vaginal birth. It was a pleasure to observe how women make sense of their birth experiences. By witnessing how the women in this study made sense of their experience, the way in which I make meaning of and understand childbirth has changed. I too am now a part of the social web of relationships that surrounds them, and likewise, they are a part of mine. I hope their wisdom and teachings will be used through me to enhance the childbirth and postpartum experiences of the people I work with. There is most

definitely a place for surgical births in childbirth, and this mode of birth is no less valuable than vaginal births. The effort and courage women use to birth their babies is worthy of recognition and acknowledgment, no less than that of vaginal births.

### Practice Implications

The present study primarily set out to examine the social responses women who have had an emergency cesarean birth receive and how they in turn, respond. This investigation was done through a response-based practice perspective which offers a more detailed account of women's experiences and the ways they respond, resist, make decisions, and ascribe meaning to their experience of the surgical birth. The findings of this study demonstrate the importance of focusing on women's responses rather than the effects of an emergency birth. Contextualizing the social interactions surrounding the birth elucidates the ways in which women respond and make sense of their experience. Analysis of the manner in which women respond to the positive and negative social responses they are provided with preserves the essence of social interactions. Having conversations that elucidate the positive social responses people receive can promote dignity, as "positive social responses are related to dignity and often to the justice and acceptance found in the social world" (Richardson & Bonnah, 2015, p. 203).

By simply focusing on the effects, or the negative psychological outcomes of having a surgical birth, we risk misrepresenting women's responses as pathology. The field of psychology is saturated in psychological theories that cast women's postpartum responses into symptomology connected to disorders such as postpartum depression, postpartum anxiety, and posttraumatic stress disorder. Narrowing our focus onto symptomology rather than responses conceals what women are responding to. Current practice assesses women's responses as an effect of childbirth, or label her experience as 'birth trauma,' and locate causes for her response

to the emergency cesarean. A couple of examples of such intrapersonal causes identified in past studies are “maladaptive coping skills,” and “prior history of mental illness.” Yet, when viewed in context, many of these symptoms are responses to some aspect of the person’s experience. Perhaps the anxiety experienced in the postpartum period can be a response to the unknown territory of parenthood, or from a lack of preferred support or people with whom they can debrief their birth experience. Our work is to help people understand why they responded in the way they did and to understand what other social processes were occurring that influenced their choice to act one way over another.

While previous research has focused on effects, these results demonstrate that a focus on responses shifts the focus from deficits to capacities. The social processes surrounding childbirth are elucidated by using this approach, as its commitment to contextual analysis allows for the development of detailed accounts of social interaction at the micro and macro level.

The findings of this study strengthen existing research that emphasizes the value of providing positive social responses to labouring and postpartum people. It adds an alternative practice perspective to guide maternal health practitioners in their work with women who have had an emergency cesarean birth. These implications are not designed to condemn mainstream psychological perspectives or the biomedical model—although they do call into question some of their weaknesses—but to simply add an alternate framework to support professionals work with pregnant and postpartum people and their families.

### Limitations and Recommendations

The methodology included a thematic analysis which is limited in that it involves the researcher’s subjective process of coding and theming. Another researcher may have interpreted the same data differently. The generalizability of the results is limited by the small sample size of

six. Although the case study analysis provided a detailed account of the participants' experience, the sample size is too small to draw any conclusions. Another limitation is that the study participants were comprised of white, educated, middle-class, women who were in long-term relationships. It is likely that the findings of this study would be quite different if the participants were from different socio-economic backgrounds, geographic locations and their relationship status differed. Nonetheless, the results answer the research questions and have provided insight into women's experiences of having an emergency cesarean birth. The study provides examples of some of the positive and negative social responses women are provided throughout childbirth and postpartum. This study furthers understanding about the way women respond and resist social responses.

Further research is needed to gain a better understanding of how women of different socio-economic backgrounds respond to emergency cesarean births, and the social responses they are provided during childbirth and postpartum. To improve validity and reliability, future studies should consider having additional reviewers of the interpretation of the data.

With respect to recommendations for practice, I have the following thoughts. It is by considering the whole system that we will be better able to support women and their families within the broader maternal health system. Medical policies and practices that support recovery and infant bonding can lead to stronger and healthier families and ease the transition into parenthood. An integrated response is needed to address the emotional and physical distress women experience because they are not prepared for surgical births or recovery. Medical professionals and childbirth educators would better prepare women for these outcomes by providing them with the information they need to be prepared. Medical professionals can decrease maternal distress by informing women, and their support partner, about the surgical

process and the side effects of medication, e.g. the shaking and coldness they may experience during the surgery. Furthermore, the consequences of surgery need to be disclosed prior to consent.

The opportunity to debrief with medical professionals about the reasons for a cesarean birth is an important factor in helping women have the information they need to process and make sense of their birth experience. Partners and families also need to be better informed about the realities of, and how to support women through, postoperative recovery.

Mental health practitioners can work with clients in a manner that shines a light on the positive aspects of the birth experience by highlighting their agency, recognizing and acknowledging the effort they put into labour in an effort to elicit a sense of pride about their birthing experience. The use of a response-based approach to interviewing women is advisable, as it allows for the construction of a dignifying account of their birth experience. A benefit of having response-based conversations with postpartum women is the elucidation of new meaning in the birth narrative women construct about their experience which draws on their agency, strength, pride, and resourcefulness.

### Concluding Remarks

This research examined women's experiences of having an emergency cesarean birth, the specific positive and negative social responses they received throughout childbirth and postpartum, and how they respond to them and their overall experience of having an emergency cesarean birth. A further aim was to investigate the relationship between the social responses received and postpartum psychological well-being. Based on the qualitative thematic analysis and response-based contextualized case studies of the social responses provided and women's responses, it can be concluded that women who receive positive social responses are more likely

to appraise their birth experience positively and hold a dignifying account of childbirth. The results suggest that women who receive social responses that are emotionally supportive, supportive of agency, and support of recovery, are associated with positive responses to childbirth and postpartum. Negative social responses, such as those that are not emotionally supportive, do not support agency, or recovery, are more likely to be responded to with emotional and physical distress. The results also suggest that childbirth is a social process as much as a physiological process. Furthermore, it can be concluded that decision and meaning making processes involved in childbirth are influenced by social relationships as well as social and medical discourse.

The use of a thematic analysis elucidated clear patterns of social responses people have to women who have experienced a cesarean birth. The use of the response-based contextual analysis built on the findings identified in the thematic analysis allowed me to reflect on the social-interactional realities described by the participants. This methodological approach offered me the opportunity to articulate the nuances of social responses in a manner that justly represents the participants' accounts. Contextualizing the social interactions surrounding childbirth illuminates the manner in which women respond and make sense of their experience. The findings demonstrated the multitude of intelligent and beautiful ways in which women respond and make meaning within the context of childbirth.

This study builds on existing knowledge that highlights the value of positive social, physical, and emotional support for postpartum women and their families. It also offers a new approach for viewing women's experiences of emergency cesarean births, one that prioritizes responses and dignity over effects and symptomology.

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Appendix A  
Recruitment Flyer



**Responding to Emergency Cesarean Births: A Thesis  
Project**

Have you experienced an emergency cesarean in the last three years? Are you interested in sharing your experience? A Masters level study is being conducted by Tanya Penna, a Master of Counselling student at City University of Seattle, which will explore how people respond to unplanned cesarean births. Participants will be asked questions about their experiences and the responses they received from the people they talked to about their birth experience.

Criteria for participation:

- 19 years-old or older,
- Experienced an unplanned emergency cesarean within the last 3 years,
- Your baby did not have neonatal complications,
- Your pregnancy was planned,
- You did not have any mental health concerns or diagnoses before or during pregnancy.

If you are interested in participating or would like more information about the study, please speak with: **Tanya Penna** by email at [tpenna@cityuniversity.edu](mailto:tpenna@cityuniversity.edu) or by telephone: 250.634.0775.

Or Allan Wade, Program Coordinator (and/or Program Director), City University of Seattle, by telephone at 250.391.7444 or email: [AWADE@cityu.edu](mailto:AWADE@cityu.edu).

## Appendix B

### Interview Questions

#### Interview Questions

##### Part A

1. What is your age?
2. How do you identify ethnically?
3. What is your relationship status?
4. Was this your first-time giving birth?
5. Was this a planned or unplanned pregnancy?
6. What was the Date/Year you had a cesarean birth?
7. Prior to your pregnancy did you have any history of mental illness?
8. Did you plan to have a home or hospital birth?
9. What type of caregiver did you have? E.g. Doctor or midwife?
10. What was being pregnant like for you? How did you feel emotionally throughout your pregnancy?
11. Did you feel well supported throughout your pregnancy?
  - a. Labour and delivery?
  - b. Postpartum?
12. Did you have a doula?
13. Did you have any other interventions leading up to the cesarean section? E.g. Induction, pain medications, breaking of waters etc?
14. How long was your labour?

15. Have you experienced symptoms of anxiety, depression, and/or posttraumatic stress since giving birth to your child?
  - a. Did you receive a diagnosis?

### **Interview Questions**

#### **Part B**

(The following questions are adapted from Bonnah, Coates, Richardson & Wade's (2014)

Response-Based Contextual Analysis Interview Guide.)

1. How did you come to know you would need an emergency cesarean birth?
2. How did you respond to hearing that you would have to have a cesarean delivery?  
What did that mean to you?
  - a. What was going through your mind when you heard you would need a cesarean delivery?
  - b. What were you feeling?
3. Was anyone else present when you found out you would need an emergency cesarean delivery?
4. How did the other medical professionals respond upon learning you would need to have an emergency cesarean birth?
5. Who else knew that you needed an emergency cesarean? How did they respond to hearing that you would need a cesarean delivery?
6. Who have you talked to about, or debriefed with, about having an emergency cesarean birth?
7. What details about the birth have you shared with other people (e.g. parents, friends, medical staff, family, etc.)?

8. How did they respond when you told them about the details of your cesarean birth?
9. How did you feel about the responses you got from the people you told?
10. Which responses were helpful to you? Can you tell me why you found these responses helpful to you?
11. Which responses were unhelpful or harmful? Can you tell me why you found these responses unhelpful or harmful to you?
12. How did you respond to the unhelpful responses? How do you make sense of your decision to respond this way?
13. Is there anything else you think would be useful for me to know about your experience?