

THE EXPERIENCES OF WOMEN WHO UNDERGO AN EMERGENCY
CESAREAN SECTION: A PHENOMENOLOGICAL STUDY

By

©Julie Patricia Sullivan

A thesis submitted to the
School of Graduate Studies
in partial fulfillment of the
requirements for the degree of

Master of Nursing

School of Nursing

Memorial University of Newfoundland

May 2014

St. John's

Newfoundland and Labrador

Abstract

In this phenomenological study, the lived experiences of women who gave birth via an emergency cesarean section (EmCS) were explored. Ten women from the province of Newfoundland and Labrador, who experienced an EmCS, were interviewed and their narrative accounts were analyzed using van Manen's hermeneutic phenomenological approach. Analysis of the interview transcriptions revealed six themes: (a) disruption of a "normal" birth; (b) losing control: "given to the healthcare system"; (c) pervasive sense of fear and urgency; (d) being alone without needed support; (e) missing pieces: losing touch with reality; and (f) missing out on feeling like a new mother. The findings of this study will potentially enhance awareness and understanding of the experience of an EmCS and could be used to improve the care of women who undergo an EmCS. The findings could also be used to direct future research regarding this type of birth experience.

Acknowledgements

I am delighted to thank the people who made writing this thesis possible.

I would like to sincerely thank my thesis co-supervisors, Dr. Shirley Solberg and Dr. Cindy Murray for their continuous guidance, support, and flexibility. Without you this thesis would not be possible.

I am very appreciative of Lorraine Burrage with the Provincial Perinatal Program for offering me guidance and support in the early phases of this research. I would also like to acknowledge my former manager and mentor, Flora Brushett for her ongoing support and encouragement. To my public health nurse colleagues who assisted with participant recruitment and cheered me on along this journey, I am very grateful.

I feel that it is imperative to acknowledge the outstanding support of my family. My parents, Sean and Shirley Maher have shown me by example the meaning of hard work and instilled in me the value of education. It is because of them, I have followed my dreams. My husband Jason has been my biggest fan. He has offered me unconditional love and support in all my professional and academic endeavors. To my beautiful children, Kate and Cole, you are my sunshine and inspire me to be the best that I can be.

Last, but certainly not least, I would like to sincerely thank the participants in this study for sharing their stories with me. I truly commend each of you for your honesty and invaluable contribution to this area of research. For mothers everywhere, it is to you I dedicate this thesis.

Table of Contents

Abstract.....	ii
Acknowledgements.....	iii
Chapter 1: Introduction.....	1
Background.....	3
Rationale.....	4
Coming to the Research Question.....	7
Goal and Research Question.....	7
Chapter 2: Review of the Literature.....	8
Untoward Reactions to Birth.....	9
Posttraumatic Stress Disorder (PTSD) Following Childbirth.....	9
Research on PTSD with EmCS.....	11
Research on PTSD Comparing Different Modes of Delivery.....	17
Postpartum Depression and EmCS.....	19
Differing Reactions to EmCS.....	23
Predictors/Correlates of a Negative Birth Experience.....	27
Summary and Conclusion.....	31
Chapter 3: Methodology and Methods.....	33
Research Activities.....	34
Participants and Recruitment.....	35
Data Collection.....	37
Setting.....	38
Data Analysis.....	39

Ethical Considerations.....	40
Rigour of the Study.....	42
Chapter 4: Findings.....	45
Disruption of a “Normal” Birth.....	45
Losing Control: “Given to the Healthcare System”	49
Pervasive Sense of Fear and Urgency.....	54
Being Alone Without Needed Support.....	59
Missing Pieces: Losing Touch with Reality.....	63
Missing Out on Feeling like a New Mother	66
Chapter 5: Discussion.....	72
Disruption of a “Normal” Birth.....	73
Losing Control: “Given to the Healthcare System”	74
Pervasive Sense of Fear and Urgency.....	76
Being Alone Without Needed Support.....	77
Missing Pieces: Losing Touch with Reality.....	78
Missing Out on Feeling Like a New Mother.....	79
Chapter 6: Implications for Nursing, Limitations and Conclusion.....	82
Nursing Implications.....	82
Nursing Practice.....	82
Nursing Education.....	85
Nursing Research.....	86
Limitations of the Study.....	87
Conclusion.....	88

References.....	90
Appendix A: Information Sheet for Public Health Nurses.....	102
Appendix B: Recruitment Poster.....	104
Appendix C: Guiding Questions for Interview.....	105
Appendix D: Informed Consent.....	107
Appendix E: Socio-demographic Information.....	113
Appendix F: HREA Ethical Approval.....	114

Chapter 1

Introduction

Childbirth is one of the greatest life transitions that many women experience and how they experience this transition has important implications for their adaptation to motherhood (McGrath, 2007). Generally women expect to experience the transition in a positive and memorable way and through a natural birth or at least with limited instrumentation (Malacrida & Bolton, 2013). When those expectations are challenged, such as occurs with an emergency cesarean section (EmCS), there is great potential to experience birth in a negative and even traumatic way (Ryding, Wijma, & Wijma, 1998d). Women who experience an EmCS are deprived of the chance to prepare psychologically for the event, thus limiting their ability to adjust to this unfamiliar situation (Somera, Feeley, & Ciofani, 2010).

A number of adverse psychological or emotional, physical, and social consequences have been reported following cesarean section (CS) and in particular after an EmCS. EmCS has been associated with postpartum depression (Boyce & Todd, 1992; Fisher, Astbury, & Smith, 1997; Koo, Lynch, & Cooper, 2003) and has been identified as a contributing factor to the development of acute trauma symptoms following childbirth (Creedy, Shochet, & Horsfall, 2000; Gamble & Creedy, 2005; Ryding, Wijma, & Wijma, 1998a). Hospital readmissions for physical complications following childbirth are higher in women with CS when compared with women who have had vaginal deliveries suggesting more negative physical effects are associated with this type of birth (Liu et al., 2005). Adverse social consequences are seen when relationships with partners or spouses,

or with infants, have been negatively affected following EmCS, leading in some situations to poor sexual relationships with partners or lack of bonding with or being overprotective of infants (Ayers, Eagle, & Waring, 2006).

Not all women who experience an EmCS will develop the negative consequences that have been reported following this type of birth. For some women childbirth by EmCS might be an acceptable option, while for others it might be experienced as a major traumatic event (Ryding et al., 1998a). Most of the literature pertaining to this topic has focused largely on the psychological impact associated with EmCS and whether or not the trauma that is associated with this experience meets the stressor criterion of posttraumatic stress disorder (PTSD) (Creedy et al., 2000; Ryding et al., 1998a; Tham, Christensson, & Ryding, 2007). While we do not know for certain the frequency of EmCS, cesarean sections in general are increasingly a more common phenomenon, yet there has been limited recent research carried out on the experience of EmCS from the perspective of women who have had this type of birth. It is important to conduct such research so that we might understand how this experience affects women and whether or not the experience is still predominantly a negative experience. Consequently, the purpose of this phenomenological study was to explore the experiences of women who have undergone an EmCS. Phenomenological research can reveal the meaning of an experience so that others who read the findings from the research might appreciate and understand the experience more fully (van Manen, 1990). In addition, the findings from this study could direct future research regarding the experience and care of women who undergo an EmCS.

Background

In the province of Newfoundland and Labrador (NL), there has been a steady rise in the number of births by CS (Newfoundland and Labrador Centre for Health Information, 2011). The proportion of primary caesarian sections in NL in 2012 was the highest in the country at 22.4% compared with 18.2% for Canada as a whole (Canadian Institute for Health Information, 2012). Canada had a decline in the rates of CS over the period 1979 to 1993 that were mainly attributed to the number of vaginal births following a CS, but also because of a decline in the primary CS rate (Millar, Nair, & Wadhera, 1996). That downward trend was brief because since 1993 the number of live births by CS has increased in Canada (Canadian Institute for Health Information, 2006). In the United States (US), the rate of CS has remained stable at 31.3% from 2009 to 2011 for single births, following a steady increase in the rate since 1996 (Osterman & Martin, 2013). These reports do not provide a breakdown between elective CS versus EmCS so we do not know if the rates reflect increases or decreases in rates of EmCS. The World Health Organization (WHO) recommends a CS rate of not more than 5 to 15% in any country in order to achieve an improvement in maternal and infant health and suggests a higher rate could result in having the opposite effect (Gibbons et al., 2010).

Within the province of NL, there has been a steady rise in the percentage of births via CS. In 2010, the number of live births by CS in NL was 33%, an increase from 30.5% in 2007 (Newfoundland and Labrador Centre for Health Information, 2011). One of the limitations of the data is that it is unknown how many of these cesarean births were considered emergencies. In a recent 2010 Canadian study, 26.3% of deliveries were by CS and 12.8% of these were unplanned cesareans (Chalmers et al., 2010).

CSs are graded and classified by time from decision to delivery and the urgency of the need to perform the procedure and range from immediate because of an identified threat to the life of the mother or infant to one that can be more flexibly scheduled because of physical or other indications that are not considered emergencies (Levy, 2006). For emergencies 30 minutes is considered a standard time for the interval between when the decision is made to operate to the actual surgical operation or delivery. Therefore, an EmCS, for the purposes of my study, is one that is performed in an obstetric emergency, where complications of pregnancy occur suddenly during the process of labor and swift action (i.e., the time interval between the decision for a CS and the CS incision is ≤ 30 minutes) is required to prevent the death of mother, child(ren) or both.

Rationale

The research literature has mainly been focused on the emotional trauma associated with EmCS, but there is a need for further research to explore other aspects of this experience in order to develop broader support and provide care for these women. However, in order to give the women the support and care that they need, it is important to first understand more fully the women's experiences with EmCS. Nurses and other healthcare professionals who provide expert care for the woman throughout her labour and the subsequent birth can do much to help her have a positive birth experience (Goldbort, 2009). When nurses do not meet the expectations of care during labour and delivery, such as might happen during an EmCS, when the emergency situation dictates that care is rushed and medical decisions are required to be made quickly, women in childbirth might feel violated and angry, and this has the potential to result in an overall

negative evaluation of the birthing experience (Beck, 2004; Bryanton, Gagnon, Johnston, & Hatem, 2008; Goldbort, 2009; Ryding et al., 1998a; Yokote, 2008).

Women can be helped to have more positive birthing experiences, even if birth is by EmCS (Ayers et al., 2006). A brief counseling intervention carried out by midwives for women who had an EmCS was effective in reducing negative psychological symptoms in the postpartum period (Gamble et al., 2005). Women who participated in postpartum counseling reported a more positive perception of their childbirth experience and less posttraumatic stress symptoms when compared to women in a control group (Ryding, Wijma, & Wijma, 1998b). Some research has shown positive effects of psychosocial interventions, but that is not the case for all women. In one study on group counseling for women after EmCS, while the participants were satisfied with and very appreciative of the group counseling, it did not have any effect on how the women perceived the delivery experience and proved ineffective in reducing symptoms of trauma and postpartum depression (Ryding, Wiren, Johansson, Ceder, & Dahlstrom, 2004). Further, a randomized controlled trial of community debriefing following operative delivery by forceps, vacuum, or EmCS found that the intervention was ineffective in decreasing fear of childbirth among women who had experienced operative deliveries (Kershaw, Jolly, Bhabra, & Ford, 2005). These conflicting findings suggest that perhaps we do not fully understand the experience of women who have an EmCS and how to effectively offer psychosocial interventions or what is offered is not addressing the needs of these women. Further research into these experiences would help to better understand the experience and how to support these women.

Research has been conducted on the emotional trauma associated with an EmCS. Most of the research to date has focused largely on the development of PTSD, however according to some researchers PTSD following EmCS is an uncommon occurrence (Soet, Brack, & Dilorio, 2003). Other researchers however have identified that the experience of trauma following childbirth might actually be more common than previously thought and not always result in a diagnosis of PTSD (Beck, Gable, Sakala, & Declercq, 2011; Creedy et al., 2000; Gamble & Creedy, 2005; Stramrood et. al., 2011; Wijma, Soderquist, & Wijma, 1997). Equally important to consider is that even when trauma associated with childbirth does not result in PTSD, women might still view their childbirth experience as negative, have difficulty adjusting to their new role in the postpartum period, and be at an increased risk for having difficult and stressful future childbirth experiences (Ryding, Wijma, & Wijma, 1997).

While identification of negative outcomes following an EmCS can lead to improved interventions for women in the postpartum, perhaps there is some increased awareness and interventions nurses can employ immediately before and throughout the experience to lessen the distress that women experience. However, in order to do so it is important to more fully understand the experiences of these women throughout the EmCS. I feel that this study might contribute to our knowledge in this area by allowing women to share their experiences of having an EmCS, while shedding light on the essence of what it really means to live through an EmCS.

Coming to the Research Question

The need for the research comes not only from the research literature, but also is influenced from a reflection on my work experiences and observations as a nurse. As a public health nurse, I have had the opportunity many times to care for women who have had the experience of an EmCS. These women have often described being rushed in and out of hospital, having the EmCS and then within a day or two being discharged home feeling emotionally overwhelmed by everything they have experienced. Through my professional interactions and discussions with these women many of them have disclosed to me that they felt unprepared for the experience of the EmCS, which often resulted in feelings of powerlessness, loss of control, and extreme fear of the unknown. Other women have simply expressed feelings of gratitude for a safe delivery. Consequently, it would seem that the emotional response to an EmCS is quite varied and unique for each woman. It is for this reason I became interested in exploring this phenomenon and gaining a better understanding of what this experience means for the women so affected.

Goal and Research Question

In this qualitative research study, I used van Manen's (1990) hermeneutic phenomenological approach to explore the lived experiences of women who have undergone an EmCS. Through interviews with these women I aimed to acquire rich and detailed data as I provided each participant with an opportunity to share her personal story. The goal of the selected research method is to bring the individual's experience to life so that others might appreciate and understand it. The study aimed to answer the following research question: "What is the lived experience of women who have undergone an EmCS?"

Chapter 2

Review of the Literature

Since the primary purpose of this study was to better understand women's experiences of EmCS, this chapter I provide an overview of the research literature relevant to the topic. An extensive review of the literature was carried out using the online CINAHL and PubMed databases. Initially the search terms included "emergency", "cesarean section", "c-section", "women's experience", "impact", "postnatal", and "expectations" using various combinations of these terms. While no limitations were placed on the year of publication, only articles published in English were reviewed. Abstracts were read and pertinent articles were selected for a thorough review. Following the reading of each article selected, the references in the article were checked for any further articles that were not identified by the literature search. This process continued until a repetition of articles occurred in the references and no new references were being identified. Early articles located through the original search included a number of studies on posttraumatic stress and EmCS so I expanded the online search with the same databases and included the terms "psychological" and "posttraumatic stress", which resulted in a number of studies not included in the original search. I repeated the process of reading abstracts and identifying further studies from the references in the articles.

This review of the literature revealed that certain areas of research pertaining to the experiences of women who undergo EmCS have been thoroughly investigated, such as postpartum depression and the trauma associated with EmCS (Boyce & Todd, 1992; Carter, Frampton, & Mulder, 2006; Creed et al., 2000; Koo et al., 2003; Ryding et al.,

1997), while other aspects were underrepresented, such as other reactions to or feelings about the event. The purpose in this chapter is to provide a review of the selected research on EmCS under the following two main areas: reactions to birth and predictors/correlates of a negative birth experience. The review is limited to research that focused on EmCS only and that which compared EmCS with other modes of birth.

Untoward Reactions to Birth

There has been a substantial amount of literature to date that has focused on untoward reactions to birth, whether the birth was via EmCS or another means of delivery. These reactions can be categorized as PTSD, postpartum depression, and other emotional or psychological reactions to EmCS. Less research was located on physical complications (Liu et al., 2005), or relational difficulties (Ayers et al., 2006) following CS and EmCS.

Posttraumatic Stress Disorder (PTSD) Following Childbirth

A traumatic event has a number of identifiable characteristics (American Psychiatric Association [APA], 2000). It happens suddenly and unexpectedly, it disrupts a person's sense of control and challenges the person's beliefs, values, and basic assumptions about the world and others. The stressor that precipitates the trauma is usually experienced with intensity, terror, and helplessness and there might be a perception of life-threatening danger, accompanied by physical and emotional symptoms (APA, 2000).

In 1980, the third edition of the Diagnostic and Statistical Manual of Mental Disorders established PTSD as a diagnostic category (APA, 1980). Since that time, revisions have broadened the criteria for the disorder to include experiences involving

actual or threatened death or serious injury. These revisions have led to research on childbirth as an event that could be perceived as traumatic and able to precipitate a posttraumatic stress reaction (Soet et al., 2003). Criteria for PTSD are as follows: (a) Criterion A: stressor or trauma; (b) Criterion B: intrusive recollection or intrusiveness; (c) Criterion C: avoidant/numbing or avoidance; (d) Criterion D: hyper-arousal; (e) Criterion E: duration [of greater than one month]; and (f) Criterion F: functional significance (APA, 2000). These criteria are usually applied to determine if a person can be considered to have PTSD. Only those who meet all the criteria can be considered as having PTSD, however meeting some of the criteria can also be classified as partially symptomatic of PTSD.

A great deal of the research effort to date on this topic has tried to establish whether or not the trauma associated with EmCS can be classified as PTSD as specified in the APA Diagnostic and Statistical Manual of Mental Disorders: Fourth Edition, Text Revision (DSM-IV-TR; APA, 2000). A traumatic childbirth experience can overwhelm a woman's normal coping abilities and create the potential risk for PTSD (Gamble & Creedy, 2005), however, because the end result of childbirth, i.e., having a healthy mother and newborn, is usually positive, any trauma associated with that childbirth might often be overlooked (Ryding et al., 1998a).

It is challenging to estimate the prevalence of PTSD following childbirth. A review of research on the prevalence, risk factors, and management of PTSD associated with childbirth by Lapp, Agbokou, Peretti, and Ferreri (2010) indicated that there was much variation associated with this condition. In their review Lapp et al. estimated that a diagnosis of PTSD could range from 0-6%, with a further 22-40% partially symptomatic,

and 20-50% reporting trauma following their childbirth experience. Because of methodological differences among studies, authors advised that these numbers need to be treated with caution.

Research on PTSD with EmCS

The effects of PTSD following an EmCS are profound and often chronic (Beck et al., 2011; Tham et al., 2007). There have been several studies to date, which have investigated the development of posttraumatic stress reactions and PTSD in response to an EmCS. Much of this early research was conducted in Sweden by Ryding and co-researchers (Ryding et al., 1997; 1998a; 1998b; Ryding, Wijma, & Wijma, 1998c; 1998d). One of the earliest studies carried out by this group of researchers attempted to determine whether or not women who underwent EmCS experienced the event as traumatic and if that trauma led to PTSD (Ryding et al., 1997). To establish whether PTSD was present or not the women had to meet all of the criteria as specified by the American Psychological Association, which at that time included trauma, intrusion, avoidance, and arousal. These researchers interviewed women between 1 to 9 days post EmCS and again at 1 to 2 months postpartum. They found that approximately three-quarters of the women at both interview times did meet the first criterion, e.g., the birth was perceived to be traumatic, however other criteria were met by fewer women and none had met all the criteria to establish a diagnosis of PTSD. What the researchers did find was that a small percentage of the women experienced varying degrees of posttraumatic stress reactions and for some this reaction persisted up to 1 to 2 months post EmCS. Most women in this study experienced the EmCS as a traumatic event thus necessitating a need for further investigation into the psychological aspects of EmCS.

Having discovered that women experience EmCS as a traumatic event and that some women go on to develop PTSD, these researchers questioned what if any predisposing factors might make some women more likely than others to develop posttraumatic stress reactions following an EmCS. Using the data obtained from their 1997 study, the researchers determined that several factors, including a past history of a perceived negative patient experience, feeling mistreated by medical staff, and the lack of a supportive partner relationship, were related to the development of posttraumatic intrusive stress reactions (Ryding et al., 1998c).

To further explore the concept of PTSD following EmCS, Ryding et al. (1998a) interviewed 53 women 1 to 5 days following their EmCS to determine if that event met the criterion of being a stressor or trauma. They also explored the women's predominant thoughts and feelings in some depth over six phases of delivery of the infant that ranged from arrival at the hospital to their first encounter with their infant. They recorded what the women believed were contributing to the reported thoughts and feelings. They used phenomenology to analyze the data on the women's experiences. Predominant thoughts and feelings varied considerably during the six phases of delivery. Concern about delivery and the EmCS were the main thoughts until the surgery began and after surgery thoughts about the baby were the main concern. For a number of women throughout the delivery process the prime thought was always about the baby. Predominant feelings showed greater variation in that upon arrival for delivery more women felt confident and safe. For approximately half of the women, when they began to realize they would have a CS, increased anxiety and fear was reported than any other emotion. While fear continued to be experienced at the time of the decision to operate, relief was the more

common feeling at this point. Again on the operating table anxiety and fear predominated, with happiness and satisfaction being the emotion reported by the majority of participants following the event. The research is important in that it demonstrated how thoughts and feelings change over the course of an EmCS and women focus on either their own safety or that of the infant depending on the phase of the delivery. The research also demonstrated that factors, such as, previous obstetrical events, relationships with and support from partners and hospital staff, and commitment to a normal delivery were influencing factors on their thoughts and feelings. Despite finding that new mothers also experienced feelings of happiness, these researchers concluded that most women who underwent an EmCS had a variety of negative feelings and reported their delivery experience as traumatic enough to meet the diagnostic criteria of PTSD.

In a prospective, longitudinal study by Creedy et al. (2000), the relationship between childbirth and PTSD was investigated and largely supported previous findings. In this study, 5.6 % of the women met all of the criteria for the diagnosis of PTSD, while an additional one third described their birthing experience as traumatic and were found to be partially symptomatic for the disorder. An important finding here was that the development of PTSD and/or the presence of trauma symptoms in the participants was not solely related to the experience of having an EmCS. These researchers found that having a high level of obstetric intervention, which is the case with an EmCS, combined with a perceived lack of care during childbirth was a strong predictor, and was more likely to be statistically significant for the development of trauma symptoms and subsequent PTSD than either of these factors alone. Unlike other studies, these researchers did not find any association between the development of PTSD and the

presence of antenatal factors such as preparedness for the delivery and having a supportive partner.

In a later study Soet et al. (2003) examined the prevalence and predictors of women's experiences of psychological trauma during childbirth. Over one-third of the participants in their study described their experience of childbirth as traumatic. Even though only a small percentage (1.9%) of the women met all the diagnostic criteria for the diagnosis of PTSD, it is important to recognize that over 30% reported being partially symptomatic of the disorder. Having a CS was one of the factors identified as a predictor of a traumatic childbirth experience, however, the authors did not specify whether the CS was planned or considered to be an emergency. They also found an association between the experience of trauma during childbirth and a history of sexual trauma and lower levels of perceived social support. Women who experienced sexual trauma had a 12 % higher risk of a traumatic delivery experience. The history of sexual trauma was considered a confounding factor so that trauma could not solely be associated with childbirth.

Psychological trauma symptoms following childbirth are debilitating and could well compromise a woman's ability to provide care for her baby (Gamble & Creedy, 2005). An important question would be how common is psychological trauma following childbirth? Equally important would be does the amount of trauma vary with type of birth? Some researchers have attempted to answer these important questions. In an effort to examine the relationship between type of birth and symptoms of psychological trauma, 400 Australian women were interviewed about their birthing experience within a couple of days after birth and again between 4 and 6 weeks postpartum. Thirty-three (9.6%) of

the women interviewed reported symptoms consistent with the diagnosis of acute PTSD, while approximately one quarter of the women expressed various other psychological trauma symptoms. Additionally, these researchers found that type of birth was associated with the development of trauma symptoms at 4-6 weeks postpartum. Women who had more intrusive delivery experiences, such as an EmCS or an operative vaginal delivery, had a greater chance of developing PTSD compared to women who experienced an elective CS or a natural vaginal birth. Approximately one third of the women who developed PTSD had experienced an EmCS (Gamble & Creedy, 2005).

More recent research pertaining to the presence of posttraumatic stress symptoms following EmCS by Tham et al. (2007) indicated that 25% of women were partially symptomatic for the disorder at 3 months postpartum, while 9% of the women reported severe reactions that could well meet the diagnostic criteria for PTSD. These researchers explored the coping abilities of the women in stressful situations and were the first to report a relationship between coping ability and the development of PTSD following EmCS. Women who were deemed to have lower coping abilities in stressful situations, or a lower 'sense of coherence' suffered more posttraumatic stress symptoms. Another key factor that was identified as being associated with an increased risk for the development of posttraumatic stress symptoms and subsequent PTSD included infant distress that led to the EmCS. For these women, the distress of their unborn baby resulted in feelings of intense fear as well as fear of threatened death or injury, which fulfilled criterion A of the DSM-IV for PTSD. Women who were able to achieve full cervical dilation during their labour were found to have less PTSD. These authors attempted to explain this finding by suggesting that women who were able to have a fully dilated cervix might have felt they

accomplished more in their efforts to deliver the infant and/or suffered more exhaustion, and therefore were perhaps more inclined to accept the operative delivery.

Evidence for EmCS being a risk factor for PTSD has been supported through systematic review (Anderson, Melevar, Videbech, Lamont, & Jorgesen, 2012). These authors reviewed 31 quantitative studies on PTSD in the postpartum period. They found that EmCS was an important predisposing risk factor for PTSD but did note that some studies did not differentiate between EmCS and planned CS and that a few of the studies included did not find a relationship between EmCS and PTSD.

Other researchers have also attempted to establish to what extent women evaluate the births of their infants as traumatic. In a study in the Netherlands, Stramrood et al. (2011) compared the development of posttraumatic stress reactions in home versus hospital births. The women who gave birth in hospital settings suffered more trauma symptoms and PTSD compared to the women who delivered at home, however this finding disappeared once complications and interventions during delivery were controlled for in their analysis. Having an assisted vaginal delivery or an EmCS were associated risk factors in the development of posttraumatic stress symptoms and this finding is in line with previous studies (Gamble & Creedy, 2005; Ryding et al., 1997; Ryding et al., 1998d).

Not all researchers have found a relationship between EmCS and distress. MacClean, McDermott, and May (2000) found that the women who underwent an EmCS were more satisfied overall with their childbirth experience and reported being less distressed than women who required instrumental delivery, such as an episiotomy. Forty first-time mothers in England responded to a questionnaire about their childbirth

experience at 6 weeks postpartum. The highest levels of distress were reported from women who had instrumentally assisted vaginal deliveries. These women perceived a high risk of serious injury and poor pain control throughout their delivery experience. On the contrary, women in this study who experienced an EmCS perceived a lower risk of serious injury and reported significantly higher levels of satisfaction with pain control. A longer hospital stay for the women who experienced an EmCS accompanied by increased medical attention and support might have contributed to a decrease in psychological distress among this group of women. The findings of this study are in conflict with findings of other research conducted in this area.

Research on PTSD Comparing Different Modes of Delivery

PTSD can also occur following a normal or spontaneous vaginal childbirth. Other researchers have attempted to determine the extent to which PTSD differed between EmCS and other modes of delivery. In one study on the prevalence and possible predictors of posttraumatic stress type symptoms following “normal” childbirth, 3% of the women met all the criteria for PTSD, while approximately one-quarter were partially symptomatic for the disorder (Czarnocka & Slade, 2000). One of the limitations in many of the studies on PTSD after childbirth is that we do not know to what extent this condition might have been present prior to delivery, as many studies did not measure or control for this. To gain a better understanding of the nature of PTSD following childbirth, and to overcome this limitation, Ayers and Pickering (2001) were the first authors to explore whether or not the symptoms of PTSD experienced following birth occur as a result of the birth itself or are in actuality, a continuation of the disorder from pregnancy. Two hundred and eighty nine women participated in the study and completed

a questionnaire to assess for symptoms of PTSD in pregnancy and again at 6 weeks and 6 months postpartum. To control for underlying symptoms of PTSD, women who reported severe symptoms of PTSD or clinical depression during pregnancy were removed from the study. Of the 289 women, 2.8% and 1.5% met all the criteria for a diagnosis of PTSD at 6 weeks and 6 months postpartum respectively. These authors estimated that the number of new cases of PTSD that resulted from childbirth might fall between 0 and 3% at 6 months postpartum. In many cases PTSD is resolved within the first 6 months postpartum. However, women that continue to suffer from the disorder beyond 6 months might go on to develop a chronic form of the disorder.

The results of a two stage national survey in the US by Beck et al. (2011), carried out to increase the understanding of prevalence rates of PTSD following childbirth, confirmed previous research findings. Data pertaining to PTSD was obtained between 1 and 12 months postpartum and then again 6 months later. Of the women in the study, 69% had a vaginal delivery while 31% had a CS, with no breakdown by elective or EmCS. A large proportion of women in this study experienced childbirth as traumatic. Nine percent of the women fulfilled all of the DSM-IV criteria for PTSD following their delivery experience, while 18 % of the women reported a high level of posttraumatic stress symptoms, partially fulfilling the diagnostic criteria for the disorder. Predisposing factors for the development of posttraumatic stress symptoms found to be significant in this study included a lack of a supportive partner, which supports the findings of previous researchers (Ryding et al., 1998c; Soet et al., 2003), an increased level of depression and physical complications postpartum, as well as being less likely to engage in healthy behaviors including exercising, managing stress, getting adequate sleep and eating a

balanced diet. A list of other demographic as well as antepartum, intrapartum and postpartum factors were also identified as being associated with significantly higher levels of posttraumatic stress, such as a loss of control and occurrence of unanticipated events during childbirth. There was no control for pre-existing posttraumatic stress symptoms, thus limiting the association between childbirth and the development of PTSD.

Postpartum Depression and EmCS

Increased awareness of the negative implications of postpartum depression and the recognition of the disorder as a significant issue pertaining to the health and well-being of childbearing women and their families have resulted in increased demands for care and intervention from health care providers (Koo et al., 2003). Estimates of the prevalence of postpartum depression vary. In Canada 6.5 to 8.46% of women have minor depression and 4.5 to 8.69% major depression in this period (Davey, Tough, Adair, & Benzies, 2011; Lanes, Kuk, & Tamim, 2011). More globally, postpartum depression is estimated to affect 5.8 to 14.5% of mothers at 3 to 4 months postpartum (Banti et al., 2011) and has the ability to negatively impact the mother, family, and child.

Findings in earlier studies indicated there might be an association between EmCS and postpartum depression. Boyce and Todd (1992) collected data from 188 women to determine if women having an EmCS had a greater risk of developing postpartum depression at 1, 3, and 6 months postpartum. The participants were separated into three groups representing the following modes of delivery; EmCS, forceps, and spontaneous vaginal delivery. Edinburgh Postnatal Depression Scale (EPDS) scores were compared across all groups and results indicated that women who experienced an EmCS scored

significantly higher on the EPDS and were over 6 times more likely to develop postpartum depression at 3 months postpartum when compared with the women who had a forceps or a spontaneous vaginal delivery. These researchers noted similar personality traits among women in all three groups, thus confidently attributed the increased risk of postpartum depression to the EmCS event. The authors acknowledged that women who underwent an EmCS suffered more physical pain in the initial postpartum period compared to women in the other groups. Because postpartum depression was more prevalent at 3 months postpartum for women in the EmCS group, the authors suggested that an EmCS has the potential to have a greater psychological impact than physical impact, especially when unmet expectations surrounding childbirth resulted in feelings of disappointment, failure, and a loss of control.

Fisher et al. (1997) also investigated the psychological effects of obstetric procedures. In this study, 272 primiparous women were interviewed late in pregnancy and again in the early postpartum period to determine what if any obstetrical interventions had a negative psychological impact on the women. Mode of delivery was identified as having the most significant impact on mood and self-esteem, with those women who experienced a CS reporting the most significant psychological impact. These women reported being more irritable and depressed and had difficulty in thinking clearly. They continued to experience higher levels of anxiety postpartum when compared with women who had vaginal deliveries. The authors suggested that factors such as being separated from their partners, prolonged mother-infant separation, and post-delivery narcotic intake, all of which are more likely to occur with a CS, might have contributed to the negative psychological impact experienced by women who had operative deliveries.

There was no indication of a difference in psychological impact between women who experienced an elective versus an EmCS, however, the authors suggested that first-time mothers who experience an operative delivery might be more likely to suffer from depression, grief, or symptoms of PTSD.

Similar findings that support an increased risk of postpartum depression after an emergency delivery came from a later retrospective comparative cohort study by Koo et al. (2003). These researchers aimed to determine the risk of postpartum depression following emergency delivery. Participants completed the EPDS at least 6 weeks after giving birth. The women who experienced an emergency delivery, including an EmCS (n=38), vacuum (n=11) or forceps assisted delivery (n=6), were almost twice as likely to develop postpartum depression when compared with women who had a non-emergency delivery.

In contrast, findings from a prospective, population-based cohort study carried out around the same time by Patel, Murphy, and Peters (2005) on the association between operative delivery and postpartum depression did not support previous research findings that associated EmCS with an increased risk of postpartum depression. The EPDS was completed by 10,934 participants at 8 weeks postpartum, with response rates equally representing each of the delivery groups, i.e., EmCS, assisted vaginal delivery, and spontaneous vaginal delivery. There was very little difference in the odds of postpartum depression among women who delivered by EmCS or assisted vaginal delivery when compared to women who had a spontaneous vaginal delivery. These findings indicated that women who underwent an assisted vaginal delivery or EmCS were no more at risk for developing postpartum depression than women who had normal vaginal deliveries.

Carter et al. (2006) conducted a meta-analysis of the evidence for an association between CS and an increased risk of postpartum depression. These authors used Medline and PsychInfo databases to search for and review all studies that assessed for postpartum depression following CS between 10 days and 1 year after childbirth. They identified 24 studies for their review. An adverse association between CS and maternal mood was identified in five of the studies, while 15 of the studies found no significant association. The remaining four studies yielded mixed results. These authors acknowledged that their meta-analysis of the research failed to find consistent evidence to support a significant association between CS and postpartum depression and acknowledged the need for further research in this area.

More recent studies have focused on mode of delivery and postpartum depression and researchers have not found an association between the two. In particular two recent Canadian studies examined these associations and Davey et al. (2011) found that mode of delivery (vaginal versus CS) was not a predictor variable for either a minor or major depressive state in the postpartum period. This research did not identify how many of the cesarean births were EmCS. Similar findings were reported by Sword and co-researchers (Sword et al., 2011) in their large cohort study conducted in 11 hospitals in Ontario. These researchers found that mode of delivery was not significantly associated with the development of postpartum depression, however, mode of delivery by country of birth was. Among Canadian-born women, those who delivered via CS were significantly at higher risk for the disorder compared to women who had a vaginal delivery. Non-Canadian born women who had a CS were at less risk for postpartum depression compared to other women born outside Canada who delivered vaginally. While in the

latter study the researchers did not specifically separate out planned versus emergency sections for data analysis, slightly over 50% had planned sections.

Differing Reactions to EmCS

Postpartum depression and PTSD are not the only reactions or outcomes following an EmCS. The emergent nature and uncertainty that surrounds this mode of childbirth, can elicit a variety of responses from women. In the study by Ryding et al. (1998a) cited above and using phenomenology, 53 women were interviewed between 1 and 5 days post EmCS. Although the primary goal of the study was to determine if the trauma associated with an EmCS fulfilled the criteria for a diagnosis of PTSD, they found a number of other reactions to EmCS during various phases of the delivery process. Over half of the women in the study described their fear as being intense and for the majority of the women this fear was for the baby's well-being. In addition to "fear", other reactions to EmCS were: (a) "derealization" and amnesia; (b) disappointment; and (c) anger. Furthermore, one-quarter of the women felt partially responsible for the EmCS in the days following the delivery. The authors concluded that an EmCS has the potential to evoke a variety of negative feelings in a new mother, including fear, guilt, and anger, which can adversely impact her perception of the childbirth experience.

The same group of researchers conducted a further study and categorized women's experiences of EmCS into various patterns based on their narration of the event (Ryding, Wijma, & Wijma, 2000). Twenty-five women who following an EmCS were interviewed within the first few days of giving birth and then again between 1 and 2 months postpartum. In addition to identifying the perception of a traumatic childbirth experience as well as posttraumatic intrusive stress reactions, four other main themes or

patterns were identified from the narratives of the women at 6 weeks postpartum: (a) confidence whatever happens; (b) positive expectations turning into disappointment; (c) fears that come true; and (d) confusion and amnesia. The women who reported having positive expectations that turned into disappointed were identified as having the highest prevalence of posttraumatic intrusive stress reactions, thus suggesting that early identification and intervention for these women is necessary to prevent the development of posttraumatic suffering.

Somera et al. (2010) explored the experiences of nine Canadian women who underwent an EmCS. The women were interviewed within days of having an EmCS. The researchers identified seven predominant themes that best described how the women experienced the EmCS. Some themes were consistent with previous research while other new themes were identified. The themes identified were: (a) It was for the best; (b) I did not have control; (c) Everything was going to be okay; (d) I was so disappointed; (e) I was so scared; (f) I could not believe it; and (g) I was excited. Loss of control was a prominent theme related to the fact that the emergency delivery often does not allow women to adequately prepare for the event and might even led to a feeling of helplessness. The use of reassuring thoughts by the women helped to restore a sense of control and thus reduced their distress during the EmCS. The majority of the women were described as being “well- educated” and the authors questioned whether or not this resulted in a more profound sense of loss of control. It is important to acknowledge that even though the women reported a variety of emotional responses to the EmCS, they might not have experienced these emotions simultaneously. A possible limitation of the

study is the broad range of the decision to incision time interval of 15-95 minutes, which might have been a contributing factor in the women's variation of emotional reactions.

Building on previous research and attempting to gain a deeper appreciation of the process of entering into motherhood by means of an EmCS, Herishanu-Gilutz, Shahar, Schattner, Kofman, and Holcberg (2009) explored the effect of an EmCS on 10 first-time mothers. The women's childbirth expectations as well as the ways in which previous life experiences might shape the woman's perception of her EmCS were also examined. The women were interviewed between 1 and 1.5 months postpartum and the main theme identified was related to a disruption in mother-infant relationship. The women described feeling detached and experienced difficulty connecting with their newborn baby. Other themes that describe the women's experience of becoming a mother after an EmCS were also identified: (a) alienation from the infant on encountering her/him; (b) primal difficulties in holding; (c) a 'mechanistic' pattern of childcare at home; (d) over-apprehension; and (e) fear of a cradle death. A sense of loss of control, fear, and anger were also reported and are consistent with previous research findings discussed earlier in this chapter.

Descriptive phenomenology was used by Goldbort (2009) to describe the unexpected birthing experiences of 10 women who delivered via various modes of instrumentally assisted vaginal deliveries, EmCS, or some other means that was unanticipated by the women. In keeping with findings from previous research, Goldbort found the women all experienced a birth that was different from what they had planned for themselves, thus a disruption in their birth plan. Through the narratives of these women, the author was able to identify a lack of three key "elements" from the women's

childbirth experiences, which included caring, connection, and control. The women expressed feeling unimportant and as though their needs did not matter. They described feeling disconnected from the nursing staff and feeling powerless as a result of losing control over their birthing experience.

Research pertaining to the emotional impact of EmCS has been conducted in other cultures as well. In Japan Yokote (2008) examined the experiences of 11 women who underwent an EmCS for various reasons that included fetal distress and failure to progress in labour. The decision to incision time interval in this study ranged from 15-69 minutes. The participants were interviewed at 2 and 7 days postpartum and their thoughts, feelings and overall experience prior to, during and following the EmCS were explored. Six predominant themes were identified based on the women's accounts of the experience, some of which support previous findings. As in previous studies, these women expected to have a normal or natural delivery. When the decision for surgery was made, they felt a sense of shock and even described feelings of disappointment. For the most part, the women experienced fear for both themselves and their babies, but also felt a sense of responsibility and trusted in the expertise of the medical staff to carry out the surgery. The safe arrival of their healthy newborns brought a sense of relief to the mothers, however they still experienced flashbacks of the feelings of fear, as well as the severe physical pain they endured during labour. The women experienced strong feelings of affection towards their newborns and reported feelings of peace upon meeting their babies for the first time. The majority of the women seemed to forget their difficult labour that ended in an EmCS once they saw their baby. They described a combination of positive and negative feelings.

However, by a week postpartum they were able to escape the “vicious cycle” and felt supported in their abilities to provide care for their newborn.

Predictors/Correlates of a Negative Birth Experience

While we have much research on the negative effects of birth and some of the consequences of such as an experience, there has been more limited research into the precursors of trauma associated with childbirth. The literature on childbirth presented several possible predictors of trauma and a negative appraisal of birth, including a perceived loss of control in labour (Czarnocka & Slade, 2000), low levels of support and trait anxiety (Czarnocka & Slade, 2000; Soet et al., 2003), previous mental health issues (Czarnocka & Slade, 2000; Wijma et al., 1997), fear of childbirth in late pregnancy and general anxiety (Wijma, Ryding, & Wijma, 2002), nulliparity (Wijma et al., 1997), and a history of sexual trauma (Menage, 1993; Soet et al., 2003). Findings from other research have indicated that having an EmCS is a strong predictor of a negative birth experience (Cranley, Hedahl, & Pegg, 1983; Seguin, Therrien, Chapagne, & Larouche, 1989; Waldenstrom, 1999; Waldenstrom, Borg, Olsson, Skold, & Wall, 1996), while Waldenstrom, Hildingsson, Rubertsson, and Radestad (2004) concluded that women who had an EmCS were at the greatest risk of negatively perceiving their childbirth experience.

Dissatisfaction with the childbirth experience, especially when it occurs with the first delivery, has been shown to result in fewer subsequent pregnancies (Gottvall & Waldenstrom, 2002). Approximately 25% of women who delivered by various methods of childbirth, expressed negative and dissatisfying birthing experiences at 2 days postpartum while 20% of women continued to report dissatisfaction at 3 and 9 months

postpartum (Larsson, Saltvedt, Edman, Wiklund, & Andolf, 2011). To further explore factors that might contribute to a negative and dissatisfying appraisal of childbirth, Waldenstrom and co-researchers (2004) obtained data from a large cohort of women during pregnancy and again at 2 months postpartum. Seven percent of the women who participated in this study reported a negative childbirth experience. Various risk factors to their negative appraisal of the birth included unanticipated medical complications, such as EmCS, inadequate social supports, a lack of perceived control during labour, and a lack of caregiver support in pregnancy, during labour, and following childbirth. Women who had an EmCS were deemed to be at the greatest risk for a negative childbirth experience.

Another factor that has been identified in the literature as being a predictor of a negative childbirth experience is fear of childbirth during pregnancy. Waldenstrom, Hildingsson, and Ryding (2006) conducted a prospective study to determine how prevalent fear of childbirth is among Swedish women and to explore its association with rate of CS and childbirth experience in general. Women were asked to complete a questionnaire at 16 weeks gestation and again at 2 months postpartum. Approximately 11% of Swedish women reported experiencing fear of childbirth during their pregnancies and in the absence of counseling services, a prenatal fear of childbirth was associated with an overall negative childbirth experience. Recent research has indicated that having a previous EmCS is associated with fear of childbirth, while fear of childbirth, in turn, is associated with a negative birth experience (Nilsson, Lundgren, Karlstrom, & Hildingsson, 2011).

Recognizing a gap in the literature and in an attempt to determine the role of culture, history, politics, and policy on women's perception of childbirth, Baston and colleagues, replicated an English study to further explore the factors associated with women's appraisal of their childbirth experience in the long-term (Baston, Rijnders, Green, & Buitendijk, 2008). The study took place in the Netherlands in 2004 and included 1310 women. The researchers hypothesized that women, who predominantly come from a culture of home birthing, would appraise an EmCS more negatively than their English counterparts. The rate of EmCS in England was much higher, almost double, the reported rate in the Netherlands, particularly for primiparous women. The study hypothesis was supported. Compared to women in England, women in the Netherlands generally felt more negative about their birthing experiences regardless of the mode of delivery. Factors such as having an EmCS or assisted vaginal delivery, fear for the baby's life, negative perceptions of caregivers, and a medical complication following childbirth were all identified as predictors of a negative childbirth experience. Induced labour and fear for their own well-being were also predictors of a negative appraisal of childbirth specific to the Dutch women.

Cranley et al. (1983) compared the perceptions of childbirth among three groups of women; those with vaginal delivery, planned CS, and EmCS. The women who had an EmCS reported the least positive birth experience with women who had planned CS and vaginal deliveries having more similar scores and generally feeling more positive. The authors felt that some of the difference could be attributed to the women in the latter two categories being able to exercise more control over events than the women with an EmCS. Similarly, Bryanton et al. (2008) measured perceptions of childbirth experience

for women having vaginal, planned CS, and EmCS births. Data from self-report questionnaires and chart reviews of 652 women, including 82 who had EmCS, were collected between 12-28 hours postpartum. Type of birth, degree of awareness, relaxation, and control, helpfulness of partner support, and being together with the infant following birth were identified as the strongest predictors of a positive perception of childbirth across all birthing groups. The strongest predictors of perception of childbirth among women in the EmCS groups included degree of awareness and control, worry about the infant, enjoyed holding the infant, and being pleased with the birth. Unlike previous research in this area, women who had a planned CS had a more negative perception of their childbirth experience compared to those who had an EmCS or vaginal birth. Differences in the findings of the study by Bryanton et al. might have been influenced by an underrepresentation of women having cesarean births as well as from women with complications.

More recent research has aimed to further explore factors that might be associated with a negative childbirth experience. Larsson et al. (2011) followed 541 women from late pregnancy up until 9 months postpartum to determine factors that influenced a woman's perception of childbirth. Of the 541 participants, 247 were scheduled for a CS while the remaining 294 participants anticipated a vaginal delivery. Women were asked to respond to questionnaires about their personality traits, socio-demographic and health information, as well as their expectations of childbirth. One-quarter of the participants reported a negative childbirth experience at 2 days postpartum, while 20% still perceived the experience as negative at 3 and 9 months. Memory of pain during the birthing experience was identified as being highly predictive of a negative childbirth experience,

even when women had received analgesic medication for 1-2 days post delivery. Increased length of hospital stay, being worried late in pregnancy and experiencing high levels of irritation were also related to a more negative appraisal of birth. These authors were the first to identify certain personality traits including indirect aggression, verbal aggression, irritation and guilt to be associated with having a negative birth experience.

Summary and Conclusion

Through a review of the literature on the experience of an EmCS, it has been acknowledged that while there has been a great deal of research carried out in certain areas pertaining to this topic, such as the psychological impact of an EmCS, some inconsistencies among study findings have been identified. Much of the literature is associated with reactions to birth, particularly on the association of PTSD and trauma symptoms with EmCS, and this literature is perhaps more open to criticism than the other areas. Many of the studies pertaining to childbirth and the development of PTSD are retrospective in nature and failed to control for confounding variables, such as a history of anxiety or previous trauma, which might limit the strength of the research findings.

Other researchers have attempted to link a higher incidence of postpartum depression with EmCS when compared to other modes of delivery. Again while there is some support for the relationship, there are conflicting findings. However, other negative reactions, such as fear, guilt, and anxiety have been linked to EmCS. Alternatively, research into the predictors or correlates of negative birth experiences have been conducted. EmCSs have consistently been found to be important, but are not the only predictors or correlates of negative birth experiences as other factors have been identified.

In conclusion, while much research has been done on EmCS it was anticipated that the findings from this study would add to the body of knowledge in this area by revealing lived experiences of EmCS. As well, many of the researchers have not clearly defined what would be considered an EmCS and as a result have included women with broad decision to incision time intervals, which might have resulted in varied and inconsistent emotional reactions to the EmCS. In this study I clearly defined EmCS and only women who met the specific definition criteria were included.

Chapter 3

Methodology and Methods

The methodology used for this research was phenomenology. Phenomenology is a philosophical movement that formally began with the work of twentieth-century philosopher Edmund Husserl and was then further developed and modified by other philosophers, including Heidegger, Gadamer, and Merleau-Ponty (van Manen, 1990). Since its introduction as a philosophy, phenomenology has evolved to also include its adoption as a research methodology employed as a guiding framework for use in qualitative research, and because it aims to explore lived human experience, it has gained particular popularity in the areas of the human sciences (Dowling, 2007).

In this study van Manen's (1990) approach to phenomenological inquiry was used as a guide in an attempt to capture the uniqueness of the lived experiences of women who had an EmCS. van Manen's approach to phenomenology as a research method is derived from the Dutch school and essentially combines aspects of both descriptive and interpretive phenomenology (Dowling, 2007). From a purist perspective, descriptive phenomenology is used to describe lived experiences, while interpretive phenomenology is used to make interpretive sense or meaning of lived experiences (Lopez & Willis, 2004). van Manen's approach to phenomenological inquiry aims to reveal unexplored phenomena or essences, while also revealing the meaning of these experiences (van Manen, 1990). van Manen does not support Husserl's view of bracketing, but rather embraces Heidegger's view on this aspect of phenomenology by posing the question, "If we simply try to forget or ignore what we already "know," we may find that the presuppositions persistently creep back into our reflections" (van Manen, 1990, p. 47).

Therefore, van Manen (1990) recommended holding our presuppositions about the phenomenon under study at bay, with the belief that a complete bracketing or reduction of them was impossible. Ultimately, van Manen's approach to phenomenology aims to uncover the essence and meaning of lived human experience by "...discovering aspects of or qualities that make a phenomenon what it is and without which the phenomenon could not be what it is" (van Manen, 1990, p.107).

For phenomenological research to be effectively carried out and interpreted in a way that truly reflects lived human experience, the researcher must ensure the implementation and integration of six essential research steps (van Manen, 1990). These "research activities" are identified by van Manen as: (a) turning to a phenomenon which seriously interests us and commits us to the lifeworld; (b) investigating experience as we live it rather than as we conceptualize it; (c) reflecting on the essential themes which characterize the phenomenon; (d) describing the phenomenon through the art of writing and rewriting; (e) maintaining a strong and oriented pedagogical relation to the phenomenon; and (f) balancing the research context by considering parts and whole (p. 30). In an attempt to achieve a more thorough understanding of the lived experience of an EmCS from the perspective of the women who have gone through it, I employed these research activities.

Research Activities

The phenomenon in question is of great interest to me. Being a public health nurse, I am in a position where I provide care on a regular basis to women who have experienced an EmCS. It is not an uncommon event in my practice. Gaining a better understanding of what this experience means for these women and being able to identify

ways to better support and provide care is something that is of utmost importance to me. Personally, I have not had the experience of an EmCS, therefore I cannot begin to fully understand what this experience is like. Although I have read about EmCS and what to expect from women, my knowledge and understanding of EmCS is filtered through the theoretical and clinical literature on the topic. To gain a better understanding of how women live through the experience of an EmCS and what the experience actually means, I turned to the women's "lifeworld" and I interviewed women who have had the experience of an EmCS. Through conversational interviews with these women, I was able to gain a beginning understanding of what the experience of an EmCS was like for them. I was able to identify themes that were essential to this experience. Then through the art of writing, questioning, reflecting, and rewriting and repeating these actions, as outlined by van Manen (1990), I was able to create a text from the experiences of each of the participants through the themes that I identified that were reflective of their unique lived experiences. Phenomenological text is successful when the reader is able to see things that otherwise would not be apparent (van Manen, 1990). Through the process of identifying individual themes (the parts) reflective of the experience of an EmCS, I was able to gain better insight into the overall meaning of the lived experience of this phenomenon (the whole). As well, to further assist in the development of my themes I used Merleau-Ponty's (1962) four lifeworld existentials, namely lived space, lived time, lived body and lived human relations, as guides to my reflection.

Participants and Recruitment

For participants I targeted women 19 years of age and older who had given birth to a live, healthy infant via EmCS within the 12 months prior to the study. I wanted

women who were able to give legal and autonomous informed consent and without the added distress of poor outcome for the infant. The time frame was selected because of the retrospective nature of phenomenological research (van Manen, 1990) and the necessity of allowing some retrospection on the part of potential participants, but yet not distancing themselves too far from the experience. Ten female participants who were willing to share their experience volunteered for and participated in this study. Twelve other women approached me about participating in my study, but did not meet the inclusion criteria because it had been longer than 12 months since their EmCS. Two of these women experienced an EmCS over 30 years ago! The fact that these women were interested and willing to participate in this study after so many years speaks to how important this topic is for the women who have had this experience. I even had one woman from New York City who contacted me by email to determine her eligibility. She stated that she had heard about the study from a friend. The interest shown in this study affirms for me just how significant this issue is for these women.

Participants were recruited through two methods; first, through collaboration with public health nurses employed within Eastern Health and second, through a recruitment poster. The public health nurses were informed about the study details and were then asked to screen live birth notification referrals for potential study participants (see Appendix A for the information sheet provided to the public health nurses). The public health nurses briefly discussed the study details with potential participants and provided them with my contact information. The women then contacted me if they were interested in participating in the study and upon contact I determined their eligibility to take part in the study. The recruitment posters with information about the study were displayed in

selected areas, such as nursing clinics, physician offices, and community resource centers (see Appendix B for the recruitment poster). Both methods of recruitment proved to be equally effective for recruitment of participants to this study.

The study participants consisted of 10 women living in eastern Newfoundland. The average age of the participants was 28.5 years, with a range of 23-34 years of age. All of the participants had partners. Half of the women were married, while the other half reported being in a common-law relationship. Nine of the women had a college or university level education, while one participant had been educated at the graduate school level. All of the women in the study worked, with the exception of one stay-at-home mother. Six of the women were employed full-time, three part-time, and one reported being self-employed. The time span from the EmCS to the study interviews ranged from 2 weeks to 7 months, with a mean time of 4.5 months post EmCS.

Data Collection

Data collection consisted of an audio-taped face-to-face conversational unstructured interview with each participant. Conversational interviewing, which is a flexible style of interviewing, allows for a more open dialogue between participants and researcher. Throughout each interview I sought clarity of the data as needed through additional questioning. I also advised the participants that if I required further clarification of the data once it had been transcribed, I would make a short follow-up phone call to seek clarification. Each participant was receptive to having the phone call, however, it was not felt to be necessary.

The use of the interview in hermeneutic phenomenology enables the researcher to acquire a more thorough understanding of the phenomena of interest through exploration

of the participant's narrative account of the experience (van Manen, 1990). Interviews were conducted at a convenient time for the participant (see Appendix C for guiding questions for the interview). Each participant was interviewed alone in an effort to promote comfort and to allow for the expression of her thoughts and feelings. Open-ended questions and, when necessary, prompts were used to encourage the participant to elaborate further on a relevant topic. Interviews naturally came to an end when the participant had related her experiences as fully as possible and signaled she had nothing more to add to the experience. The length of the interviews varied with each participant, but most lasted between 30 and 60 minutes. Written, informed consent for the interview was obtained from each participant prior to the beginning of the interview (see Appendix D for Consent Form). With the participant's agreement, the interview was audio-taped. Prior to data collection on the experience of an EmCS I administered a short survey on demographic information (see Appendix E) in order to describe the group of participants.

Setting

The study took place in St. John's and nearby communities in NL. I had offered a choice of setting for data collection keeping in mind comfort, safety, and convenience for all parties. In all instances the interview was conducted in the participant's home. Because I am a public health nurse engaged in home visiting I was comfortable with this arrangement, as would be the case for the women who would also be used to having postpartum follow-up through a home visit. The setting for each interview was comfortable, convenient, and conducive for the discussion of a potentially sensitive topic.

Data Analysis

Data analysis began with the transcribed interviews. The verbatim transcriptions were first assessed for accuracy and errors prior to data analysis. In hermeneutic phenomenology the meaning of the experience is very important. Therefore, in my data analysis of the textual representations of the interviews, I searched for the meaning of the EmCS experience for the women. Careful attention was paid to words the women used to represent their experiences as well as the context in which they used these words.

In keeping with one of the suggested approaches to data analysis by van Manen (1990), I used the selective or highlighting approach. This method permitted me to isolate themes and thematic statements and thus form thematic descriptions from the transcribed taped conversations. This selective approach requires the researcher be attentive to the data, in this case an audio taped and transcribed interview, through careful listening and reading. Through this careful and systematic process I was able to identify words or expressions used by the participants that spoke most directly to the experience of an EmCS. I met with my thesis co-supervisors following the first interview to discuss interview quality and to begin data analysis. As the data were collected, I had the interviews transcribed, and I met regularly with my co-supervisors to consider data analysis and the progression of the study.

Once I was confident that the themes that I had identified were the “essential” themes in this experience, and these themes were agreed to by my thesis supervisors, I engaged in the process of writing and rewriting as suggested by van Manen (1990). Essential themes are unique to the phenomenon of interest and learning to identify these exclusive themes has been cited as one of the major challenges of phenomenological

research (van Manen, 1990). To check if the themes are essential or not to the experience van Manen suggests we ask the questions of how fundamentally important each theme is to the overall experience and if we remove one of the themes, are we left with the phenomenon we are attempting to understand? While reflecting on the themes, I questioned whether or not each theme was essential by asking questions such as, “Is this phenomenon still the same if we imaginatively change or delete this theme from the phenomenon? Does the phenomenon without this theme lose its fundamental meaning?” (van Manen, 1990, p. 107).

Ethical Considerations

Ethical approval for the study was granted through the Health Research Ethics Authority (HREA) at Memorial University (see Appendix F). HREA follows the Tri-Council Policy Statement (TCPS) on Ethical Conduct for Research Involving Humans (2010). One potential ethical consideration was a conflict of interest in that my dual position as public health nurse and researcher could be seen as putting pressure on women to participate in this study. To avoid any appearance of coercion or pressure, as the primary researcher, I was not involved in any initial participant recruitment. A public health nurse in the region described the study to potential participants and provided them with my contact information or women responded to my poster. Several participants contacted me when they found out about the study through other women who had been informed by their public health nurse or saw my poster. Once contacted by a potential participant, I determined their eligibility and willingness to participate at that time. I discussed the study details, purpose, risks, and benefits with each woman who contacted me and also emailed a copy of the consent form for her to review. If a participant agreed

to participate after being fully informed of the study via telephone and reviewing the emailed consent form, a mutually agreed upon time and place for the interview was then arranged.

A second ethical consideration was that of fully informed consent. At the beginning of the interview, I reviewed the study details with the participant and provided her with a paper copy of the informed consent form. Written informed consent was obtained at that time. Prior to collecting any data I made sure that any question the participant had about the study was answered.

A third ethical consideration was that of degree of risk to the participant as a result of taking part in the research. I did acknowledge that reflection on and discussion of the experience could evoke distress for some of the participants as previous researchers have found that EmCS can be traumatic and one symptom found with the trauma is that of reliving of the trauma, which I would be asking those so affected to do. In one case in this study, a participant became quite emotional and cried as she relived the experience of her EmCS. I asked her if she would like to stop the interview, but she choose not to do so and wanted to continue. I let her know that I completely understood and respected her decision if she did not wish to continue with the interview, but she stated that she was fine and requested to continue. I made sure that she was not in any emotional distress before I left her home. This participant stated that she had a very strong support system in place and that she was aware of public health and mental health services in the area, as well as the Mental Health Crisis Line that she could avail of if she felt it was necessary. Before leaving her home, this participant appeared to be upbeat as she was laughing and she assured me that she was fine and stressed that she was appreciative of the opportunity to

share her experience. Prior to each interview, I advised the participant that she could stop the session or take a break at any time. I also reminded the participant of this throughout the session. I reminded each participant of the option to withdraw from the study at any time without affecting future nursing care. I also encouraged each participant to only tell me what she felt comfortable revealing.

A final ethical consideration was participant confidentiality and the protection of participant anonymity in the study findings. To ensure this, I used a pseudonym chosen by each participant (see Appendix E). I kept all audiotapes, written transcripts and consent forms locked in a filing cabinet to which only I have access. Audiotapes were transcribed and all data will be kept for 5 years as mandated by HREA. Participants were made aware of all measures implemented to ensure that confidentiality and anonymity are protected.

All participants in this study received a \$25 Walmart gift certificate as a token of appreciation for their time and interest in participating in the study. HREA granted approval for the gift cards, but did specify that the gift card was not to be advertised on the study recruitment poster and I complied with this requirement. Each participant received the gift card only at the end of the interview.

Rigour of the Study

Rigour in research refers to the credibility of the work carried out. It is a critical appraisal of the extent to which something is valid or legitimate. There is controversy about the question of rigour in nursing research using phenomenology mainly because it is an individual researcher's interpretation of the methodology and the appropriate criteria to apply (de Witt & Ploeg, 2006). de Witt and Ploeg (2006) developed a framework to

critically appraise rigour in interpretive phenomenological research that consists of the following five main criteria or “expressions”: (a) balanced integration; (b) openness; (c) concreteness; (d) resonance; and (e) actualization (p. 215).

Balanced integration refers to the “congruence between the philosophy, the researcher, and the research topic” (de Witt & Ploeg, 2006, p.224). Using hermeneutic phenomenology and in particular the research activities suggested by van Manen (1990) assisted me in keeping a balanced integration. In collecting and analyzing the data I kept in mind the phenomenon of an EmCS and attempted to understand that as a lived phenomenon and used prompts to understand how women experienced that in time, space, relationships, and body.

Openness refers to the degree in which the research is open to scrutiny (de Witt & Ploeg, 2006). As a public health nurse, conducting face-to-face interviews, I was aware that some of the participants might have responded within the context of a home visit to a new mother, which public health nurses conduct, and focused on how they were doing at present. Through any interactions with the women I reinforced how even though I was a public health nurse, my role in this study was a researcher and I encouraged each participant to express herself openly and honestly and talk about the EmCS. My role was not to give advice or nursing care, but to listen and prompt the women to talk about their experience, which I believe was achieved.

The third expression addressed was that of concreteness. This expression allows the reader to be placed within the context of the phenomenon of interest through the use of various examples that enable to reader to relate the phenomenon to everyday life (de Witt & Ploeg, 2006). The direct use of quotes, excerpts taken from the stories of my

participants, allows the readers to relate to the experiences of the women. The identification and development of themes provides insight and understanding into what the lived experience was like for these participants.

The fourth expression is resonance, which refers to the “felt effect” that is cast upon the audience when study findings are read (de Witt & Ploeg, 2006, p. 226). Readers of the words of the participants that I selected might be emotionally moved or have an epiphany about what the experience of an EmCS was like for the women. For example, the following words by Meghan, one of the study participants, will enable readers to begin to understand what it was like to go through an EmCS:

And I started screaming and I kept saying, “Oh my God! Oh my God!” and I was screaming and I was saying (in a louder tone) “Oh my God!” It was hurting so much and (sobbing) the anesthesiologist was just tapping me on the shoulder and he was holding onto my arm and he was just saying, “It’s going to be okay. It’s going to be okay. We are going to catch up.” (Sniffles, takes a deep breath, sighs) But I felt every inch of him [the surgeon] cutting.

Chapter 4

Findings

The purpose of this qualitative study was to explore the lived experiences of women who have undergone an EmCS. In this chapter the findings of this study are presented. Data were thoroughly and carefully examined and six essential themes were identified from the experiences of the women in the study as they described what their EmCS was like. The following themes were identified: (a) disruption of a “normal” birth; (b) losing control: “given to the healthcare system”; (c) pervasive sense of fear and urgency; (d) being alone without needed support; (e) missing pieces: losing touch with reality; and (f) missing out on feeling like a new mother. The themes are presented in the next sections.

Disruption of a “Normal” Birth

The EmCS was a major disruption in the desires and plans that the women had for their pending birth. The suddenness of the decision to perform an EmCS and the events surrounding it were felt by most as major disruptions in their birthing process. Disruption is defined in the online etymology dictionary as, a word coming from the Latin “disruptionem” “a breaking asunder” or to “break apart, split, shatter, break into pieces” (http://www.etymonline.com/index.php?allowed_in_frame=0&search=disruption&searchmode=none_). For all participants, including the single participant who had experienced a previous operative delivery, the EmCS created a situation quite different from what had been expected. Each participant began the journey of pregnancy with the assumption that

at the end of pregnancy, she would have a “normal” and in most cases, a natural, drug-free delivery, or at least that was the outcome she had hoped and worked towards. This hope ended with the abrupt decision that an EmCS was necessary. The disruption was further marked by the nature of the circumstances that necessitated this type of emergency, and it did not allow the participants time to prepare at least psychologically for the event.

Jane had a planned cesarean section with her first pregnancy and was adamant that she did not want to have another cesarean birth. To prepare this time, she took hypnobirthing classes, hired a doula, and left her first obstetrician in search of another who supported vaginal birth after cesarean (VBAC) in her pursuit of a “normal” delivery. Throughout the interview, she stressed that even when she was experiencing unbearable pain and physical exhaustion during her labour, she was determined not to have a cesarean delivery. Her hopes were disrupted by her physical condition and thus began the erosion of her birth plan, one disruption at a time.

I was completely exhausted...I'm not giving up yet you know. I'm still gonna have this baby naturally. No c-section. So I needed an epidural. I wasn't planning on having an epidural, but I was just too flipping exhausted so I got the epidural.

The experience of the EmCS was a major disruption in how Kim had envisioned her delivery, but in a very different way than Jane. A motor vehicle accident (MVA) led to the interruptions in Kim's plans for an idealized childbirth and made the EmCS a necessity. Kim ended up having a general anesthesia to deliver her baby a month before her due date. When asked what her expectations of childbirth were Kim recalled,

Three children. I wanted to go all natural labor. I wanted to do it without any drugs or anything. I wanted to do it all natural and everything.

She went on to explain that even though, in one sense, she was relieved that she did not have to go through the pain of a vaginal delivery, she wanted to have that experience that she had been prepared for throughout pregnancy. She recognized that although labour and birth are hard work, she would come out of it with a sense of pride and accomplishment and knowing that she had been an active participant in the process. She said,

I really wanted to experience it like, cause to me, you just, I don't know, he was just handed to me instead of me actually pushing and feeling the pain and actually being happy for all the pain I went through to have him.

Instead of the anticipated birthing experience Kim admitted, "It was nothing like I thought it would be. It was all opposite."

Jean also required a general anesthesia for her EmCS following a uterine abruption. Prior to her labor she had discussed with her husband her wishes for a natural, drug-free labor and delivery. She described the vision of her delivery that she had in her mind as being her "happy place" and went on to explain:

For me, it was always that moment when you deliver the baby and they put the baby up on your chest and getting to that point. So every time I had a contraction, that's what I was visualizing, that's how I got through it, like just visualizing, this is going to lead to that moment, so I can do it.

Unfortunately for Jean, that highly desired, long awaited moment did not come. A medical emergency necessitated the use of a general anesthesia that rendered Jean unconscious and incapable of getting to her “happy place” and seeing through her birth plan. The magnitude of the disruption that Jean experienced was profound. She went into her labour and delivery with a drug-free birth plan in mind that was not to be realized because of medical circumstances. Jean explained,

Probably the best way of putting it is when you go into something and my biggest concern was whether or not I could do it without drugs and then to come on the other end of it in the state that I was in, it was depressing. It was depressing for the first few days...

Jessica, now a third time mother had based her expectations for a normal birth on what she had experienced with her previous pregnancies and although she knew each birth could be different, what happened to her was far from anything she had expected. She recalled,

I was expecting to go in, have labor, push the baby out in no time at all and go home. And it totally wasn't like that.

She said that when the nurse told her that she was going to be admitted, she was “ecstatic” and she could remember thinking, “Perfect. I’m gonna have this baby out in no time. Two pushes and he’s gonna be out.” Her birth was far from what she expected to have. She felt that there was absolutely nothing that could have prepared her for what she

went through with the EmCS. She explained, “Nothing prepares you. Definitely not. No preparation period whatsoever.”

The EmCS created an inadvertent situation, disrupting the childbirth experience that each of the participants had envisioned for themselves. For most of the women it was something that was totally unexpected, unfamiliar, and unknown. Some of the participants said that even though they were informed about operative deliveries during their prenatal education classes and/or television, they did not pay attention to this information as they felt that it did not apply to them because they were not planning to have a CS and it did not enter their mind as they were experiencing what they would consider normal pregnancies. For the single participant who experienced a previous planned CS, even though she was familiar with the procedure of a cesarean birth, the EmCS was still very unexpected and distressing because she had hoped for a normal vaginal delivery the second time around.

Losing Control: “Given to the Healthcare System”

As with any true emergency, the ability to control or have any power over the situation becomes further and further from reality, making it impossible to predict or even process the upcoming sequence of events. The experience of an EmCS fits this pattern. A predominant theme identified by these women is how they felt they were losing control as the events that led to the EmCS took place. They could only be considered as onlookers as the emergency situation seemed to dictate what happened next. They vividly described their powerlessness as any sense of control disappeared, as they relived the fast-paced series of events that lead up to their EmCS.

Looking back on the events that led up to her EmCS and recalling her initial reaction when she was told that she had a prolapsed cord and would require an EmCS, Jessica could remember immediately trying to assert some control over her situation by resisting the decision made by her doctor. She remembers pleading with the nurse, “I can’t [have an EmCS] ’cause I got two other kids at home...is there any other possible thing we could do?” Increasingly choices by patient and health care providers became limited in the situation. Jessica went on to describe how hurried events were,

Then she hopped on my gurney with me and that was it. We were off and we were into the operating room (OR) within seconds and that’s the way it went.

This sense of losing control and the powerlessness that ensued was best summed up by Jessica, who no longer felt she had any agency left, much less any say in what was happening when she said, “You are totally given to the healthcare system. You are given to the doctors and nurses that are there in front of you and [you] go your best basically.”

Anne recalled her sense of powerlessness as well, but in a different way than Jessica. She described losing control and feeling helpless a number of times throughout the birth. Anne had been admitted to the hospital after her membranes ruptured at home and she had to wait over 30 hours before being induced. The powerlessness that Anne experienced began with her inability to achieve pain control. Her contractions were coming on strong and fast and she requested an epidural for relief. Anne’s nurse advised her that she could not have the epidural at that time and administered morphine to her. This was not something that Anne wanted to take, but she felt as though it was her only option. She not

only recalled the lack of pain control despite the narcotic, but also ultimately ended up receiving an epidural and still did not have pain control. Anne was septic at this point because her membranes were ruptured for so long and she felt nobody had figured it out. Because of her professional knowledge, Anne knew that she should not have been left 30 hours before being induced, and felt her concerns were not taken seriously. She can remember feeling helpless and losing all sense of control when her concerns were repeatedly dismissed:

And then I said it that night. Like this was at 12 hours. I was like, 'I need to get down there.' I said to one of the nurses, 'like I'm at a really high risk of getting an infection' and she said, 'no you're not.'

Anne felt an additional sense of powerlessness because despite her professional knowledge, she was unable to negotiate a resolution to her concerns and went on to describe her efforts to get some further intervention,

I said to one of the nurses, 'like can you phone down and find out how much longer this is going to be before I get induced cause this is, like, I'm getting concerned that I am going to get an infection because I'm at a risk.' And she said, 'no you're not' ...like she tried to down play it.

Because of her previous cesarean birth, Jane was determined to avoid the same fate the second time around. She went into the birthing experience with confidence and felt very much in control of her birth plan. As labour progressed and untoward circumstances presented dictating the need for an EmCS, her confidence

and sense of control slipped away. Eventually, Jane felt powerless and saw her childbirth experience being completely in the hands of her care providers. She recalled the following:

So I was fully dilated for 8 hours and finally Dr. [Name] came in and said, 'No, it's been too long. Your uterus is datdatdatdada. We got to get you in for that section.' And I think I just...I felt completely deflated, defeated. And, so they came in and they started getting me ready and I'm here feeling completely powerless and helpless and they wheeled me in onto the table and here I was, doing exactly what I was hoping not to do and so I'm dealing with all of that in my head and so they opened me up. I was completely deflated when they told me I had to have the section.

Elizabeth was a week overdue when she got a call to go into the hospital to be induced. As she recounted the events of that day, Elizabeth described an escalating sense of powerlessness and losing control. Looking back, she stated that she never even wanted to be induced, but felt pressured by others to go ahead with the induction. Then she recalled her resistance to receiving the pitocin infusion. She explained how she had watched a documentary about the risks of pitocin and had decided long before her labour that did not want to receive it. Elizabeth spoke to her physician, but he did not agree and advised her that refusing the pitocin, was actually putting her baby in danger. Elizabeth listened to the advice of her physician, but once again felt as though she had no control over her labour. As her labour progressed, Elizabeth's loss of control intensified. She can remember vividly

the moment when the obstetrician said the word “forceps” and how she immediately looked around the room for her nurse in desperate pursuit of reassurance. Elizabeth explained how she had trusted her nurse and had developed a rapport with her and upon hearing of the need for the use of forceps, she remembers looking to her nurse for support and in an attempt to regain some sort of control over the situation. She recalled the situation:

I trust her. I’m looking for her...and with that Dr. [Name] said, ‘Who are you looking at?’ She said, ‘Who are you looking at?’ and I stopped. I was like so scared at the time. I looked down at the foot of the bed and like, ‘Ah no one’ and she was like, ‘Yeah that’s right. We’re the only ones that matter now.’ She said, ‘Look down here.’

This response was not only intimidating for Elizabeth, but left her feeling completely vulnerable, powerless, and as though her wishes for childbirth were irrelevant. She knew in that moment that she had lost all semblance of control.

Christina also described losing control and feeling powerless during her EmCS. She said that it only took about three minutes from the time the surgeon made the incision to the time her baby was born, but it felt like forever in her mind. She described her thoughts as racing and she focused all her energy on trying to calm herself through the “rollercoaster” of emotions that she experienced. Christina felt as though she had “no control” over what was happening to her and her baby and this feeling continued after the baby’s birth. She too felt quite passive in the whole process. Christina recalled, “I felt like

it was just gone, I really had no control. He [baby] wasn't in, obviously he wasn't in me. He wasn't in my reach. . . . I couldn't hear him anymore. He was in another room . . . ”

Pervasive Sense of Fear and Urgency

Fear is a distressing emotion, aroused by impending danger. Whether the threat is real or imagined, each individual's response to the threat is unique, varying in intensity and response. All of the participants in this study described experiencing fear at some point throughout their EmCS. For most, the fear was for their baby's well-being and they felt a strong sense of urgency to “get the baby out” as soon as possible. Some of the participants described being fearful for their own lives at times and expressed dread of the aftermath of the EmCS. In addition to the fear experienced by the participants in this study, they also sensed fear in their husbands or partners, and in some instances other family members. The felt sense of being rushed to surgery heightened their sense of fear and caused them to feel the urgency as well.

Perhaps the most powerful expression of fear during an EmCS was that described by Meghan in her account of her experience. Meghan's fear grew as she recognized worry in her husband and mother. She repeatedly described herself as being in a state of confusion and in her “own little world”, which now she understands was a result of the severe toxicity her body was experiencing. This confusion added to her fear. Meghan can remember feeling like “something was wrong” and then fearing the worst. She described the whole situation as being urgent and “really extreme”, increasing her sense of fear. At one point, she recalled a nurse trying to put the bottom piece back on to her bed and when she could not get it on, she just threw it across the room. Meghan cried and sobbed continuously as she relived the horrific events of her EmCS and the fear and pain that she

experienced throughout the entire experience. Through the sobbing and tears, Meghan explained, “I knew everything was wrong then [when she was being rushed into the OR].” The intense sense of fear that Meghan endured is evident in the following excerpt from her interview:

So then they wheeled me in the OR and they moved me onto this...well....board, I’m gonna say it was just like a, a crucifix and made me spread my arms out and it was really really hurting me. And I remembers saying, ‘My back. It’s hurting my back’ and they were holding me down...and my husband wasn’t there yet...and with that they just started cutting me open. And I started screaming and I kept saying, ‘Oh my God! Oh my God!’ and I was screaming and I was saying ‘Oh my God!’ It was hurting so much (sobbing) and the anesthesiologist was just tapping me on the shoulder and he was holding onto my arm and he was saying, ‘It’s going to be okay. It’s going to be okay. We are going to catch up.’ But I felt every inch of him cutting. And I remember looking up at the ceiling and all the lights and it just, that’s all I could see.

Her sense of fear described bordered on being terrifying. Jessica, a third time mother, described her EmCS as being “super terrifying”. Following the news that she required an EmCS because of a prolapsed cord, she described herself as starting to “freak out”. Initially, her fears were around the well-being of her unborn son and the sense of urgency she felt is evident in her statement, “I needed the baby out to see if he was healthy.” She worried that the meconium he had passed could have

been aspirated and feared that he would have to be taken to the neonatal intensive care unit. As the EmCS progressed, Jessica began to fear for her own life. She recalls lying in the OR hearing voices and machines all around her and remembers looking at her husband and saying, “I think I am going die...if I go to sleep, I’m afraid I’ll die.” Once the baby was delivered, Jessica’s thoughts became consumed with the fear of the aftermath of the operative delivery. She worried about how she would be able to manage caring for all three of her children at home by herself once her husband had to return to work away from home. That was the hardest part for Jessica. She stated, “I was very relieved that he was safe and healthy, but I just knew what I had to face...I did not want to have to go through that recovery and deal with my other kids.” She stated that it was “...really, really scary. It was definitely up there on my list of scary moments for sure.”

Urgency and fear also marked Kristine’s delivery experience. As her physician debated the need for a surgical procedure, she recalled feeling very impatient and expressed a compelling need to get her baby out. She worried about the risks of meconium aspiration to her baby. She can remember pleading with her physician, “Well if there’s meconium and you have already said that we need a section, well just section. Just don’t wait any longer!”

Anne was also fearful for her baby’s life and indicated a compelling sense of urgency. She recalled being “...worried that she [baby] wasn’t going to make it”. She can remember just wanting to get that baby out and recalled saying, “I don’t care. You can cut me open. I don’t care, just get her out!”

Kim's fear and sense of urgency were compounded by a car accident in an isolated area and she was transported to the nearest city hospital for a thorough assessment. She could remember the fear she experienced during ambulance transport as she worried about whether or not her baby was ok. She recalls, "It was all a rush to me. It was just get him out. Make sure he was alright and everything was good." Even though Kim can remember the joy she felt in meeting her son for the first time, the intense fear she experienced continues to predominate her other emotions:

It was so cold. It was really scary...I would never want to have another kid. Not from the experience, no, the fear of it. Like the fear of being pregnant again and going through what I went through like, I don't know. I wanted three children before, but not now. And just the car accident and everything, that's it. Like, I don't want no more [children]. There's more going through my head as like later on than before. Like when I first came home, it was all him. Now, it's just like, everything is coming back...Thinking about it. Thinking everything through. Like what could have happened, what could have happened, what couldn't have happened and how to avoid stuff and stuff like that.

Christina had a placental abruption during her labor that resulted in her EmCS. She could recall feeling very afraid throughout the entire process and described an intense sense of urgency to have her baby delivered. Christina remembers being afraid of losing too much blood and also worrying that the baby's oxygen would be compromised as a

result of the abruption. She remembers telling the staff to do whatever they had to do to get the baby out safe despite her fears. She recounted,

I think it was 3 minutes from the time he made the incision to the time he had him out, but it felt like forever. . . And I was like, ‘jeez just get him out so I can hear him and make sure everything is okay.’

Her expression of fear was contained somewhat because of her boyfriend’s emotional state, who she described as being “a mess” and “He was freaking out and I mean, I was too, but I was really quiet about it. I was keeping it all together”. She was later aware that at one point, while her boyfriend was in the waiting room he overheard a conversation and thought that she had actually died. He had told Christina after the fact, that all he could think about was losing her and the baby and having to tell their other son that his mommy and baby brother had died. Even after the baby was safely delivered, Christina still worried about him [her baby]. She explained,

I did hear a couple of little cries, but it was almost like, I know that he is out and he’s okay, but *is* he okay? Is he? You still got all this stuff going through your head. And I remember thinking like, is he getting enough oxygen? Like is it gonna...I mean, your worst fear is that the outcome is going to be drastic...that he wouldn’t make it or what not. But then you think is he gonna be okay? Is he gonna have any kind [of] damage, brain damage...and really nobody can tell you that.

Emma, a first time mother, who ended up with an EmCS because of a non-reassuring fetal heart rate, also described her experience as being very scary. She can remember the fetal monitor alarm sounding and people rushing into her room and flipping her from side to side. She recalled being “mostly worried about the baby’s heart rate.” She explained that after the baby’s heart rate dropped dangerously low for the third time, she was rushed into the OR. She could recall sensing an extreme sense of urgency as she was being rushed to the OR, the gurney she was lying on, banging off the walls along the way.

Being Alone Without Needed Support

The feeling of being alone without support that was needed throughout the experience is another predominant theme that emerged throughout the participants’ interviews. The participants described how alone they felt and without support when separated from their partner or not having medical staff available to answer questions.

Anne talked about how upset and alone she felt when she was told that her boyfriend that she needed to support her, would not be able to stay with her in the hospital overnight,

And then they told me that [boyfriend’s name] wouldn’t be able to stay with me. Then, I started to screech. Cause I was like, I’m here, I’m having contractions. It’s my first child and now you’re telling me that my partner can’t be with me. Like he’s gotta go home. . . I was cracked. Cause you know, you need to have some kind of support there. . .

As the course of events in Anne's labor and delivery proceeded, the aloneness she felt continued in her perceived lack of nursing staff available. She explained that her membranes had been ruptured for 30 hours before the induction process was started. During that 30 hour hospital admission, Anne acquired an infection which ultimately resulted in her need for an EmCS. Anne attributed the infection to her perceived lack of nursing staff on duty that night and insisted that she was left alone too long without proper nursing checks and care.

Meghan also felt very alone throughout her EmCS because she was unable to have her husband at her side. She was in the OR waiting for her husband, but he did not arrive and she remember how she was all alone when the incision for the section began,

I knew my husband wasn't even in yet and I knew all he had to do was put on his scrubs and he wasn't there yet and with that they started cutting me open...I looked to my side and with that...(crying) my husband was standing in the doorway and I remember the doctors said, "we're not ready for him" and the nurse took him and pulled him out and then I was just...I was thinking to myself, I need someone, I need someone.

Meghan also recalled feeling alone after her EmCS was over. A nurse came in the room and asked her husband if he would like her to accompany him to go update the grandparents who were waiting outside. Even though she knew the reason why the nurse left her was because of her husband's emotional state, it did not change the felt need for someone to be with her, "She went cause my husband was distraught. He couldn't even speak...and I remember I was just left in the room by myself...again."

Christina also experienced aloneness, but in a different way than the other participants. She felt alone in the internal struggle she was experiencing in trying to remain calm throughout the tumultuous events of her EmCS. With a history of gestational hypertension, she was fully aware of the adverse implications a spike in her blood pressure could have on her baby and on herself. She described using self-talk as a coping and calming mechanism throughout the EmCS and described feeling very alone in her struggle to do so. Christina explained, “I was dealing with stuff myself. That’s what my job was I felt like. I was there for my own mind, my own you know...most of the things that I worried about was everything going on with my blood pressure and trying to keep myself calm.”

Jane also described feeling alone in her account of her EmCS. The aloneness that she felt was related to her perceived lack of support from health care providers both in and out of hospital. Jane did not feel that the nurses on the obstetrical unit were adequately trained to deal with the complexity of care that she required. She recalled trying to tell the nurses about her catheter,

I would be like, ‘I’m having a lot of pain, like it’s clogged you know. I’m not sure what to do about it.’ And they sent the doctor a couple of times, but I don’t know. You’re just so miserable and no one really gets it and you try and tell them and they just don’t take you seriously. And I could tell that I wasn’t being taken seriously.

She was left with the feeling that her experience in the hospital was very “degrading” and “demeaning.” She explained that some days she would be left

alone in her bed all day, without once getting up to move. The following statement by Jane illustrates the aloneness she felt,

I felt like it was survival. And for my husband as well cause I knew he had a really rough time. It was really traumatic for him, just seeing me on the operating table, passing out from loss of blood and actually seeing the tangible blood right there, you know. And going through the whole thing, seeing me and having his little boy at home...I think it was hard on him as well as me and...there was no support in place at all. There really wasn't.

Even after being discharged to home, Jane continued to feel alone with minimal supports. She stated that she was not offered a home visit from her public health nurse as she had with her first child. She had tried to contact her public health nurse with a question about her catheter, but her nurse did not know the answer and did not provide her with any other resources or contacts. She recalled, "She didn't even give me a name or a number or help me figure it out or look into it for me. She just kind of was like, 'Oh I don't know.' And I had no one to call. You know, I had no one to call." Jane also described feeling alone and even abandoned after being rejected by her two-year-old son when she returned home after being in the hospital for 6 days. She recalled:

I come home and he [two-year-old son] rejected me when I came home. Cause he obviously knew something was up. I had left him. You know? And he was sick when I was gone and he was sick when I got home and yeah...I sat in this chair and I had a catheter and I was in more pain that I

had ever been in, in my life and I couldn't move...and dealing with him and his infection and trying to pay attention to him you know, trying to make him feel like everything is okay when it really wasn't.

Missing Pieces: Losing Touch with Reality

Many of the study participants described a surreal quality to what was happening to them throughout the course of their EmCS and even feeling out of touch with reality from time to time. Whether it was felt as disorientation from their medication, medical complications, the fast-paced environment of the EmCS, adrenalin, fear, or a combination of all of these factors, the women in this study experienced confusion resulting in unaccounted time and events or "missing pieces" in the descriptions of their childbirth experiences. Thus, "Missing Pieces: Losing Touch with Reality" is another predominant theme identified in this study.

The missing parts of the events made the EmCS feel somewhat unreal. "Confusion" is a word that Meghan used repeatedly as she reflected on her EmCS. The disorientation and confusion that Meghan experienced blurred her concept of reality, resulting in many missing pieces in her delivery story. She recalled, "I was ah, so confused and sick at the time that I didn't really understand what was going on..." Meghan later went on to say, "...everything just started going all blurry and blank and I guess, the drugs were kicking in or whatever and ah I, I couldn't hear my baby and I couldn't hear anything, and I just started getting right fuzzy..." Perhaps the best illustration of Meghan's state of confusion is revealed in her statement, "I was in and out

of consciousness then...and [husband's name] was trying to comfort me...but I was in my own little world.”

Kim's need for an EmCS resulted from a MVA that occurred 1 month prior to her expected delivery date. Like Meghan, she also expressed missing pieces and feelings of confusion surrounding the events of her emergency surgery. As she recounted the rush of that day, she stated, “I was, I don't know...I was just shocked. And blank. Like my mind was blank, just do whatever they wanted to do. Ah, I don't know.” As the events of the EmCS progressed, Kim became even more disoriented, and voiced that she did not fully understand what was happening to her or the reasons why certain medical decisions were being made. She admitted,

The doctors were explaining, but it was just going in through one ear and out through the other and I was drugged up and everything, so I wasn't in my right mind... I had, no clue. At the time, I was like, ‘Yes’, agreeing with them, but I really didn't know. And when I got on the operating table, it was just, I was just...I don't know. Like, it wasn't happening.

Several other participants also talked about their sense of confusion and loss of touch with reality, which resulted in missing pieces in the events surrounding their emergency cesarean deliveries. Kristine was very forthcoming about her disorientation throughout her EmCS. She remembered feeling as though she was coming in and out of consciousness at various points during her labour and delivery. When asked to recall the moment when her physician ordered an EmCS, she explained, “I was just so in and out of it, stressed and tired at that point that I can't even remember...” For Kristine, the

confusion and disorientation she experienced seemed to intensify as the events of her EmCS progressed. Throughout the interview, she repeatedly described her state of confusion and used the words “groggy”, “foggy”, and “blur” to describe her experience. At one point, she said,

I was, I guess passed out on the table and I remember waking up a little bit and her [surgeon] being up on the table and saying things but it was just so, and I guess I was just so still in pain and like half like, what’s going on? Like, why did you, did I faint? Why is this mask on me? Like you know just is the baby out yet? Is the baby yet? And then the baby wasn’t out yet and so, I don’t really, like nobody told me what was going on, but like I knew from the tone of everything that something was going wrong.

Kristine also seemed to have a very muddled perception of time throughout her EmCS. This disorientation is evident in her statements, “I don’t know how what span of time had gone by at this point...” and “so it was like, not that long...but it felt like an eternity to me,” and “I don’t remember what time I guess they brought me up to my room then.” At one point during the interview Kristine began to question her own credibility in providing the details of her EmCS experience and I feel this speaks volumes to the extent of her state of confusion and her insight into it. She stated, “So, I, I’m probably not even your best person here because I’m so foggy about it all.”

Emma also experienced disorientation resulting in missing pieces of her birthing story. She described a very fast paced situation as she was being rushed in for her EmCS and used the word “groggy” when trying to recount the exact time and sequence of

events. When asked if there was anyone who explained the upcoming procedures during the preparation process of the EmCS, Emma recalled, “No, I don’t think so. Like, I can’t really, it’s all like a blank...I can’t honestly remember everything they were telling me.” Jean also struggled with some of the details in her recollection of her EmCS. Like Emma, she also used the word “groggy” to describe her thought process following her EmCS.

Missing Out on Feeling Like a New Mother

The necessity of the EmCS had a profound effect on how the participants felt about being a mother at this time. Physical separation of the mother from her newborn as well as physical post-operative restrictions limited the women’s abilities to provide newborn care, including the immediate breastfeeding and skin-to-skin contact that many of the women had envisioned. This detachment left the women feeling as though they had truly missed out on feeling like a new mother, whereby you begin to incorporate the baby into your life and notice everything about the baby from the moment of birth. The overwhelming sense of missing out resulted in varying degrees of disappointment as well as anger and even bitterness in some of the participants. Conceivably, one of the best illustrators of this theme is Jane in her detailed account of what the EmCS took from her. She had already missed out on a natural delivery with her firstborn and attributed the operative delivery to his colic and digestive issues. Jane’s hope for a natural delivery the second time around was to experience a vaginal birth and the positive affects it could have:

It was good for the baby to come out vaginally and then you know, the skin-to-skin, the cord clamping and all the nice stuff that you get when you have a vaginal delivery and hormone rush and all those things you get. So you know, I wanted to

experience that. I've heard and read so many positive things about vaginal births that go well and so, that was an experience that I wanted to have.

Since part of becoming a mother and feeling like one is the actual birth, Jane further justified her reason for so desperately wanting this vaginal delivery:

I'm thinking that this may be my last baby so I knew that if I don't have it now, obviously if I have two sections, I'm not going to have a vaginal delivery after that. So I just wanted that positive experience of having a vaginal birth and pushing the baby out and you know that powerful feeling of...the accomplishment of having a baby.

Unfortunately, for Jane her dream of having that vaginal delivery accompanied by all the positive things that she had longed to experience was shattered when her physician ordered an EmCS. The sense of loss she had and the magnitude of her feeling of missing out can be realized in her words:

I just remember feeling completely powerless and helpless and you know, disappointed and frustrated and really, there was nothing I could do. I had done everything that I could...I feel like I missed out. I didn't get to enjoy either one of my babies as newborns and by the time that I felt well, my baby, I didn't have a newborn anymore. So I feel like I missed out completely.

For some women the loss that is associated with having an EmCS can be lasting, resulting in mixed and complex emotions. How each woman adjusts and copes to this loss

will vary as well. When asked about how she is coping with her loss now, Jane answered, “I assume it’s just time. Just as time moves on and you focus on the present, but I still think about it...I’m between being bitter and happy for women who have that experience cause I just wanted it so bad.”

Because she had a natural delivery with her first son, Christina could already appreciate the precious moments following birth and was very much looking forward to experiencing those cherished moments again. She described feeling a great sense of pride and satisfaction in the experience of being a new mother. She wanted to ensure that she could offer her second child the same degree of nurturing and mothering as she did with her first. When her second son was born via EmCS, Christina could not help but feel as though she truly missed out on the joy of this experience with him. She explained:

The nurse took my husband out and let him take some pictures and I was really happy that he did that, like that I got to see him. And then I was thinking, “Oh my God! I’m not the first one who got to see him.” Cause with my first I had him, I called it [announced sex of the baby]. I saw them pulling him out and I said, “It’s a boy!” And like I was the one who called it and they laid him on my chest and I was breastfeeding within 5 minutes. And this time, I never saw him for . . . God, it felt like an eternity.

Christina went on to describe how her baby was admitted to the neonatal intensive care unit for 30 hours following his birth. This physical separation of mother and infant paired with Christina’s post-operative restrictions, limited the time she was able to spend with her baby and left her feeling as though she was missing out on mothering her

newborn. Christina thought about her baby being alone and only having a pacifier for comfort and this thought was very difficult for her. She worried about how she would be able to bond with her baby given this situation. Christina even feared that her baby would reject her and refuse to breastfeed because of their separation. The marked sense of missing out that Christina experienced can be appreciated in her following statement:

I felt like, I felt like he wasn't mine. Not that I didn't love him, cause I did. It was nothing like that. It was just the fact that...I couldn't have him. You know, that's what it was, I couldn't have him. I felt that someone else was taking care of him. It was hard not having him with me and knowing that someone else was taking care of him that was the thing.

Meghan also described feeling robbed of precious time with her baby girl following her EmCS. After spending a week in the intensive and neonatal intensive care units, Meghan and her daughter were reunited. Even though Meghan stated that she is very grateful that she and her daughter survived and are both healthy today, she cannot help but feel robbed of precious time and is still experiencing mixed emotions related to her loss of time with her daughter. Meghan became very emotional as she recounted:

It was such a relief, but once I got home...I was so angry that I had lost that time. And I'm still angry [seven months later]. Because that's the first week of my baby's life that I missed out on and I can never get it back. You're living it through video tapes...but the way I always feel, I say, I lost that week and I will never get it back.

Kristine described the unsettling feeling of missing out on feeling like a mother to her second baby at birth. Like Christina, she had already had the ‘ideal’ birthing experience with her first child and wanted so badly to have that experience again. Even though feelings of joy and happiness existed in the moment of childbirth for Kristine, the EmCS created a tumultuous event that was emotionally overwhelming, preventing Kristine from experiencing the emotional high of becoming a mother for the second time. When asked to recount her thoughts upon seeing her newborn son for the very first time she recalled:

I don’t, just it was such an emotional overload like I remember I was thinking how much he looked like his sister and that and how happy I was that I had a little boy finally, cause now I had one of each...but just, I don’t even, but it wasn’t the same emotional [experience] with my son as it was with my first baby because there had been so much trauma in between....

Kristine went on to explain how fatigue and blood loss resulted in her inability to care for her newborn son. Having to depend on others to fulfill this ‘mothering’ role for her child was very difficult for Kristine. She felt as though everyone else could enjoy her new baby, except for her. For Kristine, the EmCS totally took away her ability to feel like a new mother. She recalled being physically restricted to her bed, unable to enjoy her baby and like a bystander, watched while other members of her family experienced the joy of her newborn. She stated, “...and then they took him away again eventually and the grandmas and everyone getting their pictures taken and everyone was off being able to do their own thing with the baby except for me, so that killed me...”

The experience of the EmCS was unique to each of the study participants, however, a number of common themes were identified. The essence of the experience is reflected in the interrelationships of the various themes. In this study, the predominant theme is that of missing out. The participants in this study missed out on so many things. They missed out on having the “normal” birth they had hoped for; on feeling autonomous during labour and delivery; on feeling the joy of childbirth; on having needed support; on having a lucid delivery; and ultimately they missed out on feeling like a new mother to their babies. The experience of the EmCS evoked a variety of emotions within the women, sometimes with a combination of emotions occurring simultaneously.

Chapter 5

Discussion

The purpose of this study was to better understand a woman's experience of having an EmCS. The themes identified give insight into this experience by identifying and giving clarity to what van Manen (1990) refers to as "the structure of meaning of the lived experience" (p. 77). In the following discussion, I will address essential themes identified in the study as they relate to the research question and to previous literature on this topic, as well as describe my interpretation of what it means to undergo an EmCS from the perspective of the women who have had this experience.

Many women view childbirth as a natural process and want to deliver their infants with as little intervention as necessary (Malacrida & Boulton, 2013). However, sometimes situations arise for these women that create a disruption in the natural sequence of events resulting in an unexpected and often very urgent operative delivery. Women who undergo an EmCS experience a wide variety of emotional responses. Exploration into the narratives of the 10 participants in this study revealed six themes related to the experience of their EmCS: (a) disruption of a "normal" birth; (b) losing control: "given to the healthcare system"; (c) pervasive sense of fear and urgency; (d) being alone without needed support; (e) missing pieces: losing touch with reality; and (f) missing out on feeling like a new mother. Listening to the personal accounts of these women as they relived their EmCS experiences has provided me with an increased awareness and understanding as well as appreciation of what this experience means for these women.

Disruption of a “Normal” Birth

While it is generally acknowledged there are different perspectives on childbirth from medical to alternative or natural childbirth perspectives, based on exchanging personal accounts of childbirth, portrayal of childbirth in the media, interactions with health professionals, and attending prenatal classes, women often construct a vision or expectation of what their childbirth will be like (Hauck, Fenwick, Downie, & Butt, 2006; Malacrida & Boulton, 2013). The introduction of birth plans, or written documentation on the type of birth a woman wants, and adoption of draft birth plans for women to adapt to their needs and desires both acknowledges and institutionalizes this vision. Thus, when an emergency situation arises during childbirth, as is the case with an EmCS, a disruption in the birth plan occurs, preventing the woman from experiencing the childbirth she had envisioned for herself and possibly resulting in a negative childbirth experience. It seems reasonable to argue that society, in many ways, has created an expectation for women to have a “normal” childbirth experience, which in turn has potentially set women up for this disruption.

Even though it is acknowledged that not all women have positive expectations surrounding childbirth (Fenwick, Hauck, Downie, & Butt, 2005), when the expectations are positive and these expectations have been met, they have a marked influence on satisfaction with the actual birth (Hauck et al., 2006). All of the participants in my study had positive expectations for both the birth itself and the outcome of the birth, yet their experience of the birth was felt as a major disruption from what they had anticipated and wanted. The suddenness of the decision, the obstetrical staff rushing about, the hurried nature of getting the woman to the operating room were felt as a state of commotion or

disorder to these women. Lived time, space, and relationships were interrupted for the women; an aspect of EmCS not often addressed. Since this disruption meant expectations for birth were not being met this led to feelings of disappointment that an EmCS was necessary. Comparable findings about disappointment with an EmCS have been reported in previous research on this topic. Women have been reported to have feelings of disappointment with unexpected operative births (Fenwick, Gamble, & Mawson, 2003; Ryding et al., 1998a; Ryding et al., 2000; Somera et al., 2010; Yokote, 2008), and even “feeling different” and excluded from other women because of the birth (Fenwick, Holloway, & Alexander, 2008). More recently, findings from Stramrood et al. (2011) identified that “broken expectations” surrounding childbirth resulted in the women’s negative appraisal of their birthing experience (p. 94).

Losing Control: Given to the Healthcare System

The uniqueness of individual birthing situations and personal characteristics combined with a variety of cultural expectations make it very difficult to comprehend the meaning of control as it relates to childbirth. Meyer (2012) identified four key attributes of control in childbirth. Feeling included and actively participating in decisions around childbirth, being informed about what to expect during labour and delivery, feeling supported and respected by care providers and being able to preserve a sense of physical and emotional control were all associated with achieving a higher overall perception of control in childbirth. Achieving a sense of internal and external control during labour has been associated with more positive birthing outcomes (Green & Baston, 2003), including a reduction in reported pain levels, as well as less negative and more positive emotions related to the birth (Tinti, Schmidt, & Businaro, 2011).

Unfortunately, for the women in my study, the emergent nature of the EmCS situation meant that medical care was rushed, limiting the opportunity for access to information and participation in decision making, resulting in a profound sense of loss of control. The women described feelings of deflation and defeat, which left them feeling powerless over the situation in which they gave birth. The women described feeling helpless and acknowledged that the fate of their childbirth experience was completely in the hands of their care providers. One woman even said, “You are totally given to the healthcare system.” This statement is significant and stands out in that it really emphasizes the magnitude of the powerlessness, vulnerability, and lack of autonomy that was experienced by this participant and others throughout the childbirth experience.

Patient autonomy in healthcare is an ideal, an ethical expectation. However, according to Sherwin (1998) it is merely an illusion. She reasoned that hospitalization and illness renders clients vulnerable and increases their chances of being controlled by their healthcare providers. Sherwin also indicated, that even in the absence of serious illness and going against their own personal preferences, patients often still feel obligated to do as told by their care providers out of fear of compromising healthcare services. That view was definitely expressed by some of the participants in my study who felt they had no choice or even say in the situation and were in the control of health care providers and the health system. Other authors have also reported the loss of control for women when they have a EmCS. Somera et al. (2010) found that women who experienced an EmCS reported a loss of control during childbirth, while findings from Fenwick et al. (2003) indicated that the sense of losing control increased when healthcare providers failed to

effectively communicate with childbearing women. This lack of control often resulted in feelings of anger and powerlessness and an overall negative perception of childbirth.

Pervasive Sense of Fear and Urgency

The experience of giving birth, which is accompanied by intense physical and mental exertion on the body coupled with the added influence of various cultural expectations, can evoke a variety of emotions for the childbearing woman (Nakano, Ferreira, de Almeida, & Gomes, 2012). Fear has been identified as a common emotion associated with the experience of labour and delivery (Fenwick, Gamble, Nathan, Bayes, & Hauck, 2009), with much of the reported fear being associated with the physical pain of childbirth (Sercekus & Okumus, 2009). The mother's fear of death or harm to herself or her baby has also contributed to the fear that surrounds childbirth (Nakano et al., 2012). All of the participants in my study described a pervasive sense of fear where their own and/or their baby's well-being was concerned and asserted a strong sense of urgency to "get the baby out" as soon as possible.

Fear has also previously been identified as a prominent theme in association with having an EmCS by Ryding et al. (1998a), who found that almost half of the women in their study were afraid of their baby dying or being injured and over a quarter of the women feared that they themselves would die or suffer a serious injury. This finding has also been reported by Yokote (2008) and Somera et al. (2010) whereby women described being fearful for their own lives and that of their baby during their EmCS. In addition to the fear experienced by the participants in this study, the women in my study also talked about the fear that they picked up in their partners and other family members. This finding has been previously reported as well (Fenwick et al., 2003; Ryding et al., 1998a;

Yokote, 2008) and might help direct future research in this area by focusing on the phenomena from the perspectives of other family members.

Being Alone Without Needed Support

Much of the research on support during childbirth is on the positive effects good support throughout labour has on the outcomes of birth, for example, good support is associated with less interventions for the birth (Baker, 2010). In my study, the participants actually framed this theme differently, in the context of how a lack of support during childbirth resulted in a more negative childbirth experience. The women described how alone they felt throughout the process and how much they were in need of support. They were separated from their partner at a time when they felt most vulnerable, felt they had nobody available to answer questions at a time when everything was unfamiliar, and also felt alone in the sense of facing an internal struggle between wanting to deliver vaginally versus being told a CS was medically necessary. Being left alone without the support they needed left the women feeling isolated, confused and/or angry which ultimately had a negative effect on their childbirth experience.

Several participants expressed dissatisfaction with the medical and nursing staff for various reasons, even to the point they felt not really cared for by the nursing staff. Previously, women have also described feeling “unsupported and uninformed” during childbirth (Fenwick et al., 2003, p. 13) and felt as though their care needs were unmet (Goldbort, 2009). Findings from Green and Baston (2003) indicated that when first-time mothers were left alone by nursing staff during their labour, they reported a fivefold decrease in the level of control they perceived. Additionally, women in a study by Nakano et al. (2012) described an authoritarian-type relationship with health care

personnel, which left them feeling mistreated and abandoned. The theme of “Being Alone Without Needed Support” identified in this study might help to strengthen the existing body of literature related to the need for support for women who have a EmCS by increasing awareness of and conceptualizing the unique support needs of women who give birth via EmCS.

Missing Pieces: Losing Touch with Reality

The sense of losing touch with reality, which often resulted in missing pieces in the childbirth experience, was another part of the women’s experiences. They felt disoriented and confused about the events surrounding their EmCS, particularly around the concept of time. The women often attributed this confusion to the fast pace of the emergency situation as well as the instability of their own state of consciousness because of extreme physical pain and the administration of various analgesic medication. Other women who have had an EmCS have also had similar experiences. Women who participated in a study by Ryding et al. (1998a) expressed “derealization” and “amnesia” following EmCS while findings from Ryding et al. (2000) indicated that women who underwent EmCS experienced “confusion and amnesia” that could have been related to various physical conditions including blood loss, high fever, pre-eclampsia, and extreme pain. While Ayers (2007) noted that women with and without symptoms of PTSD reported not remembering parts of the birth experience, it is the possible longer term negative psychological effects that the missing pieces may have on the women and whether the lack of memory results from not remembering or disassociation with the event. One of the criterion for diagnosing PTSD is avoidant/numbing or avoiding (APA, 2000) so follow-up on the missing pieces associated with EmCS takes on increasing

importance. Women who had an intense fear of childbirth described the birthing experience that lead to this fear as one in which they felt “beside” or “outside” the experience (Nilsson, Bondas, Lundgren, 2010, p. 301). Again, I feel that the confirmation of this theme in my study will add strength to existing research and enhance the understanding of the phenomenon.

Missing Out on Feeling Like a New Mother

The EmCS created a situation, which rendered the participants incapable of interacting with and providing care to their newborn babies in the immediate postpartum period. Tending to the immediate medical needs of mother, baby, or both resulted in a physical separation and prevented the women from mothering or feeling like a new mother to their babies. For some participants this period of separation was longer than for others. As well, the physical post-operative restrictions resulting from the EmCS, created a variety of challenges for the new mother that limited or prevented interactions with her newborn, such as breastfeeding, skin-to-skin contact, and being able to independently carry out newborn care in general. Some of the participants expressed that by the time they were able to enjoy their babies, they did not feel like they had a newborn anymore. The overwhelming sense of missing out, again resulted in varying degrees of disappointment as well as anger and even bitterness in some of the participants. The expression of this theme by the women in my study did not come as a surprise as similar findings have been reported in earlier research. Reichert, Baron, and Fawcett (1993) reported that women felt uninvolved and “detached” during their cesarean deliveries. One participant in that study stated that she struggled with being prevented from holding her baby immediately following birth and described feeling “empty and depressed” when her

baby had to be treated in the neonatal intensive care unit (Reichert et al., p. 163). Furthermore, the separation prevented her from being able to ‘mother’ her newborn and provide the immediate care she had hoped for such as breastfeeding. Findings by Herishanu-Gilutz et al. (2009) indicated that 80% of women who underwent an EmCS felt “detached” from their childbirth experience and this feeling was intensified for women who experienced a general anesthesia (p. 971). Women in the study by Herishanu-Gilutz et al. felt as though the EmCS prevented them from feeling the pain of childbirth and ultimately the sense of accomplishment of giving birth naturally. A very similar finding was expressed by a participant in my study who also experienced a general anesthesia.

Even more recently, there has been further support for this finding. Women in a study by Bayes, Fewick and Hauck (2012) described being “unable to be my baby’s mum” following their medically necessary cesarean birth. These women reported feeling disengaged and identified the operating room routines and protocols as preventing them from being able to take on their mothering roles following birth (p. 903). I feel that the women in my study really captured the essence of this theme with their detailed descriptions and spoke to the profoundness of what it is like to miss out on feeling like a new mother. Even more significant, I feel, is the realization by the women in my study that they will never regain this lost time or experience. This finding then raises the question of what next? How do the women move forward following such loss? I believe that this finding could help increase awareness among health care providers of this aspect of the phenomena so that they can better support and assist women who have similar experiences and perhaps even help to prevent some of the loss that they may experience.

Additionally, I feel that this finding is pivotal in directing future research on the potential long-term effects of the loss associated with an EmCS and what if anything, might assist these women as they move forward following such tremendous loss.

Chapter 6

Implications for Nursing, Limitations and Conclusion

The purpose of this chapter is to provide an overview of the implications of the findings for nursing practice, education, and research, as well as to identify the limitations of the study.

Nursing Implications

The experience of an EmCS is unique to each individual woman as is the care necessary to help support her through the unexpected childbirth experience. Nurses are equipped with the necessary knowledge and skill base and have the opportunity to provide optimal care for women during childbirth, even when it occurs suddenly as is the case with an EmCS. Findings from the current study have various implications for the nursing profession with particular emphasis on nursing practice, education, and research.

Nursing Practice

The findings of this study have implications for all nurses who practice in settings where childbearing women and their families are present, especially in the areas of perinatal and public health nursing. During perinatal care some of the participants felt as though they did not receive support from nursing and medical staff. Additionally, some of the participants felt that the staff separated them from husbands, partners, and other family members at a time when they were most in need of support from this group. They described feeling alone and often expressed a lack of nursing presence to offer support, answer questions, or discuss concerns. It would be valuable for nurses working in areas with childbearing women to have an increased awareness of the vulnerability of this

population and offer the needed support. This way nurses might be better able to offer their support by acknowledging client concerns and being more readily available to answer questions. The nurse could also determine how to include family members and/or other support people throughout the experience so the woman does not feel so alone.

Some sense of control might be restored to the woman in the perinatal period. Nurses have an opportunity to improve a woman's childbirth experience by determining her expectations for birth upon her arrival to the birthing center. Once a woman's expectations are known, the nurse can then help the woman work towards her expectations by offering realistic options, providing timely information, and anticipatory guidance that may help to increase the woman's sense of control and even prevent some of the trauma that she may experience if the birth does not go as planned. Some of the participants in the current study had limited knowledge of the operative delivery and admitted that they did not pay attention to this information during prenatal education classes. Several of the participants even reported having only ever heard about and seen a cesarean birth on television. Previous research has also supported this recommendation. Somera et al. (2010) recommended that pregnant women be made aware of the possibility of an EmCS and be educated about what to expect if it should happen.

While nurses working in all areas would benefit from being sensitive and responsive to the concerns of their patients, findings of this study indicate that it is essential for perinatal nurses to be present for the childbearing woman and her family. When the events of childbirth are unexpected, as in the case of an EmCS, it is the nurse's responsibility to be supportive and explain what is happening in an effort to prepare the woman and her partner for the event. It would also be beneficial to have the same nurse

assigned to the woman throughout the experience of the EmCS to provide continuity of care. After childbirth, it is important for the nurse to acknowledge the unexpected and perhaps traumatic delivery experience and allow the woman the opportunity to debrief by talking about the experience and having any questions answered. This may help clarify any “missing pieces” the woman may have of her experience.

Missing out on feeling like a new mother was one of the essential themes identified by the study participants. The women described a loss of early contact with their babies following birth, which prevented them from being able to fulfill their role as a new mother in the way they had hoped to. The medical conditions of both mother and infant are important considerations. However, even in situations when separation of the dyad is medically necessary, there may be interventions that could help reduce the loss of early contact between the mother and her baby. Nursing staff could provide the mother with regular updates on the infant’s condition and when possible, bring the stable patient to be with the other. Care providers could also encourage and support the father or another family member to participate in this care and recommend that even something as simple as taking photos or videos may help the woman feel more connected to her baby at a time when physical separation is unavoidable.

Findings of this study also support the importance of follow-up in the postpartum period. The participants appreciated the support and assistance they received postpartum in the hospital and also expressed how valuable it was to receive good follow-up by their public health nurse once discharged home. Nurses who practice in the area of public health have a unique opportunity to support these women and their families. Public health nurses can be informed about the potential reluctance of women to report negative aspects

of their childbirth experiences because of societal pressures to be happy with the birth of a healthy baby. Having this information may enable the public health nurses to acknowledge the EmCS and open the discussion of the experience by asking the mother about how she is coping and inquire about her social support network. Public health nurses can also make their patients aware of available resources, such as counseling and other mental health services as well as support groups in their area.

Because the trauma associated with EmCS has been so widely acknowledged and also because one of the participants in this study did experience postpartum depression, it would be important for nurses who care for postpartum clients to educate themselves about the signs and symptoms of PTSD, postpartum depression, and other psychological complications associated with traumatic delivery experiences. They could then offer improved assessment for these disorders as well as help with early intervention.

Nursing Education

It is essential in nursing education to instill the significance of fostering a therapeutic nurse-client relationship. It is invaluable for nursing students to be educated about the appropriate use of verbal and non-verbal communication skills so that they are able to effectively communicate with their clients. As well, it would be advantageous for practicing nurses to be aware of their verbal and non-verbal communication skills and be given professional development opportunities to facilitate the improvement of these skills throughout their nursing careers.

It would be beneficial for nursing education programs to provide students with adequate clinical time to acquire the necessary assessment skills to recognize the signs of an emergency during labor and delivery. Having this knowledge and experience would

allow practitioners to identify the early signs of complications and could potentially optimize outcomes for both mother and baby.

Nursing students might also benefit from a nursing education curriculum that included a thorough review of the various mental illnesses and psychological complications that can result postpartum, particularly when the birthing process is unexpected and emergent. Students and practicing nurses could be given the opportunity to receive continuing education sessions and refresher courses on how to recognize the signs and symptoms of these disorders and how to appropriately intervene.

Nursing Research

There was a great amount of interest shown by women to participate in this study indicating that this experience is something that women would like to share. A number of women had to be excluded from the current study because of the inclusion criteria pertaining to a time frame of 1 year post EmCS. Future research could expand this time frame, especially since previous research has indicated that time since birth does not appear to affect the reliability of this type of data (Creedy et al., 2000; Olson et al., 1997).

The focus of this study was to explore the lived experiences of an EmCS from the perspective of the woman. Findings of this study suggested that the EmCS also created a very unexpected and frightening experience for the husbands and partners of these women. There has been limited research completed from the perspective of the fathers. Thus, I believe that future phenomenological research based on the lived experience of the father would be beneficial.

All of the participants in this study reported having a supportive husband/partner. In some cases the husband/partner was present for the delivery of the baby, while in other

cases he waited anxiously in the waiting area for the safe arrival of mother and baby. In all cases, the husband/partner was present when medically possible and continued to offer his support to the mother in the postpartum period. Future research into the lived experience from the perspective of the single mother might result in different findings and could potentially enhance our understanding of this phenomenon from a different perspective.

Finally, there was an overall theme of loss that resonated from the study findings. The women in the study experienced profound loss in many ways and the question of how one is able to move on following such loss could be followed up through future research. Perhaps, that research could determine the long-term effects of the impact of loss associated with an EmCS and what, if anything, could help women on their journey forward.

Limitations of the Study

The aim of phenomenological research is to obtain a deeper meaning of the phenomenon in question so that we may gain a better understanding of this phenomena as it relates to the lifeworld (van Manen, 1990). While I believe that I have achieved this to some extent and even though I clarified any questions that I had with the participants during the interview to ensure that my understanding of their experience was accurate, I acknowledge that perhaps if I had done more than one interview, the study findings could be a different, deeper and richer account of the experience of an EmCS, thus a limitation of the study is that I had one interaction with each participant for the purposes of initial data collection.

The EmCS experience was unique to each of the study participants, however, all of the women described the experience as being predominately negative. Perhaps it was because of their negative experiences that these women were more inclined to participate and tell their story. Those with more negative experiences may have felt a greater need to recount the experience, than women who viewed the experience in a more positive light. This may be seen as a potential limitation of the study as the phenomena has been primarily described from the perspective of women who had negative experiences and could well have been different had women with more positive experiences participated.

Finally, the fact that I am a public health nurse might have influenced the responses of some of the participants and might also be viewed as a limitation of this study. Even though I made clear my role as researcher, participants were aware that I am a public health nurse employed with Eastern Health and they might have provided answers that they felt were of greater interest to me as a public health nurse, especially pertaining to issues around nursing care.

Conclusion

The number of births by cesarean delivery continues to rise globally. Women who expect a “normal” birth and experience an EmCS because of unanticipated events during labour and/or delivery report emotional distress in the postpartum period. Some of these women have been diagnosed with postpartum depression, PTSD and other posttraumatic stress reactions. Previous research has focused largely on the emotional trauma associated with an EmCS, but few qualitative studies have been conducted with this population to understand an EmCS within the context of the birthing mothers’ perspectives and experiences. The objective of the study was to explore the lived experiences of women

who have undergone an EmCS in an effort to reveal the meaning of the experience so that others might appreciate and understand it more fully. Ten women from eastern Newfoundland provided experiential accounts of their EmCS. Six predominant themes captured the essence of their experiences: (a) disruption of a “normal” birth; (b) losing control: “given to the healthcare system”; (c) pervasive sense of fear and urgency; (d) being alone without needed support; (e) missing pieces: losing touch with reality; and (f) missing out on feeling like a new mother. There is a prevailing sense of loss associated with an EmCS and women need assistance from their caregivers both during the event and in the postpartum to resolve some of the negative effects of the EmCS. Ensuring the woman has support throughout the emergency experience and good follow-up in the postpartum period might help lessen some of the negative psychological effects of this experience.

References

- American Psychiatric Association. (1980). *Diagnosis and Statistical Manual of Mental Disorders (3rd ed.)*. Washington, D.C: American Psychiatric Association.
- American Psychiatric Association. (2000). *Diagnosis and Statistical Manual of Mental Disorders. (IV-TR ed.)*. Washington, D.C: American Psychiatric Association.
- Anderson, L.B., Melevar, L.B., Videbech, P., Lamont, R.F., & Joergensen, J.S. (2012). Risk factors for developing post-traumatic stress disorder following childbirth: A systematic review. *Acta Obstetricia Scandinavica*, 91, 1261-1272. doi: 111/j.1600-0412.2012.01476.x
- Ayers, S. (2007). Thoughts and emotions during traumatic birth: A qualitative study. *Birth*, 34, 253-263.
- Ayers, S., Eagle, H., & Waring, A. (2006). The effects of childbirth-related post-traumatic stress disorder on women and their relationships: A qualitative study. *Psychology, Health & Medicine*, 11, 389-98. doi:10.1080/13548500600708409
- Ayers, S., & Pickering, A.D. (2001). Do women get posttraumatic stress disorder as a result of childbirth? A prospective study of incidence. *Birth*, 28, 111-118. doi: 10.1046/j.1523-536x.2001.00111.x
- Baker, K. (2010). The importance of effective support during childbirth. *British Journal of Midwifery*, 18, 665-668.
- Banti, S., Mauri, M., Oppo, A., Borri, C., Rambelli, C., Ramacciotti, D., . . . Cassano, G.B. (2011). From the third month of pregnancy to 1 year postpartum. Prevalence, incidence, reoccurrence, and new onset of depression. Results from the Perinatal

- Depression-Research and Screening Unit study. *Comprehensive Psychiatry*, 52, 343-351. doi: 10.1016/j.comppsy.2010.08.003.
- Baston, H., Rijnders, M., Green, J.M., & Buitendijk, S. (2008). Looking back on birth three years later: Factors associated with a negative appraisal in England and in the Netherlands. *Journal of Reproductive and Infant Psychology*, 26(4), 323-339. doi: 10.1080/02646830802408480
- Bayes, S., Fenwick, J., & Hauck, Y. (2012). 'Off everyone's radar': Australian women's experiences of medically necessary elective caesarean section. *Midwifery*, 28, 900-909. doi: 10.1016/j.midw.2012.01.004
- Beck, C.T. (2004). Birth trauma: In the eye of the beholder. *Nursing Research*, 53, 28-35.
- Beck, C.T., Gable, R.K., Sakala, C., & Declercq, E.R. (2011). Posttraumatic stress disorder in new mothers: Results from a two-stage U.S. National Survey. *Birth*, 38, 216-227. doi: 10.1111/j.1523-536X.2011.00475.x
- Boyce, P., & Todd, A. (1992). Increased risk of postnatal depression after emergency cesarean section. *Medical Journal of Australia*, 157, 172-174.
- Bryanton, J., Gagnon, A., Johnston, C., & Hatem, M. (2008). Predictors of women's perceptions of the childbirth experience. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 37, 24-34. doi: 10.1111/J.1552-6909.2007.00203.x
- Canadian Institute for Health Information. (2006). *Giving birth in Canada: The costs*. Retrieved from <http://publications.gc.ca/collections/Collection/H118-38-2006E.pdf>
- Canadian Institute for Health Information. (2012). *Highlights of 2010-2011 selected indicators describing the birthing process in Canada*. Retrieved from https://secure.cihi.ca/freeproducts/Childbirth_Highlights_2010-11EN.pdf

Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada. (2010). *Tri-Council policy statement: Ethical conduct for research involving humans*. Retrieved from www.ethics.gc.ca/pdf/eng/tcps2/TCPS_2_FINAL_Web.pdf

Carter, F.A., Frampton, C.M., & Mulder, R.T. (2006). Cesarean section and postpartum depression: A review of the evidence examining the link. *Psychosomatic Medicine*, 68, 321-330. doi: 10.1097/01.psy.0000204787.83768.0c

Chalmers, B., Kaczorowski, J., Darling, E., Heaman, M., Fell, D.B., O'Brien, B., & Lee, L. (2010). Cesarean and vaginal birth in Canadian women: A comparison of experiences. *Birth*, 37, 44-49. doi: 10.1111/j.1523-536x.2009.00377.x

Cranley, M.S., Hedahl, K.J., & Pegg, S.H. (1983). Women's perception of vaginal and cesarean deliveries. *Nursing Research*, 32, 10-14. Retrieved from www.ncbi.nlm.nih.gov/pubmed/6549836.

Creedy, D.K., Shochet, I.M., & Horsfall, J. (2000). Childbirth and the development of acute trauma symptoms: Incidence and contributing factors. *Birth*, 27, 104-111. doi: 10.1046/j.1523-536x.2000.00104.x

Czarnocka, J., & Slade, P. (2000). Prevalence and predictors of post-traumatic stress symptoms following childbirth. *British Journal of Clinical Psychology*, 39, 35-51. doi: 10.1348/014466500163095

Davey, H.L., Tough, S.C., Adair, C.E., & Benzies, K.M. (2011). Risk factors for sub-clinical and major postpartum states among a community cohort of Canadian women. *Maternal and Child Health*, 15, 866-875. doi: 10.1007/s10995-008-0314-8

- de Witt, L., & Ploeg, J. (2006). Critical appraisal of rigour in interpretive phenomenological nursing research. *Journal of Advanced Nursing*, 55, 215-229. doi: 10.1111/j.1365-2648.2006.03898.x
- Dowling, M. (2007). From Husserl to van Manen. A review of different phenomenological approaches. *International Journal of Nursing Studies*, 44, 131-142. doi: 10.1016/j.ijnurstu.2005.11.026
- Etymology Dictionary. (2013). Disruption (n.). *Online Etymology Dictionary*. Retrieved from http://www.etymonline.com/index.php?allowed_in_frame=0&search=disruption&searchmode=none_
- Fenwick, J., Hauck, Y., Downie, J., & Butt, J. (2005). The childbirth expectations of a self-selected cohort of Western Australian women. *Midwifery*, 21, 23-35. doi: 10.1016/j.midw.2004.07.001
- Fenwick, J., Gamble, J., & Mawson, J. (2003). Women's experiences of caesarean section and vaginal birth after caesarian: A birthrites initiative. *International Journal of Nursing Practice*, 9(1), 10-17. doi: 10.1046/j.1440-172X.2003.00397.x
- Fenwick, J., Gamble, J., Nathan, E., Bayes, S., & Hauck, Y. (2009). Pre- and postpartum levels of childbirth fear and the relationship to birth outcomes in a cohort of Australian women. *Journal of Clinical Nursing*, 18, 667-677. doi: 10.1111/j.1365-2702.2008.02568.x
- Fenwick, S., Holloway, I., & Alexander, J. (2008). Achieving normality: The key to status passage to motherhood after caesarean section. *Midwifery*, 25, 554-563. <http://dx.doi.org.qe2a-proxy.mun.ca/10.1016/j.midw.2007.10.002>

- Fisher, J.R., Astbury, J., & Smith, A. (1997). Adverse psychological impact of operative obstetric interventions: A prospective longitudinal study. *Australian and New Zealand Journal of Psychiatry*, 31, 728-738. doi:10.3109/00048679709062687
- Gamble, J., & Creedy, D. (2005). Psychological trauma symptoms of operative birth. *British Journal of Midwifery*, 13, 218-224.
- Gamble, J., Creedy, D., Moyle, W., Webster, J., McAllister, M., & Dickson, P. (2005). Effectiveness of a counseling intervention following a traumatic childbirth: A randomized controlled trial. *Birth*, 32(1), 11-19. doi: 10.1111/j.0730-7659.2005.00340.x.
- Gibbons L., Belizán, J.M., Lauer, J.A., Betrán, A.P., Merialdi, M., & Althabe, F. et al. (2010). The global numbers and costs of additionally needed and unnecessary caesarean sections performed per year: Overuse as a barrier to universal coverage. World Health Report (2010) Background Paper, 30. Retrieved from <http://www.who.int/healthsystems/topics/financing/healthreport/30C-sectioncosts.pdf>
- Goldbort, J.G. (2009). Women's lived experience of their unexpected birthing process. *The American Journal of Maternal/Child Nursing*, 34, 57-62. doi: 10.1097/01.NMC.0000343867.95108.b3
- Gottvall, K., & Waldenstrom, U. (2002). Does a traumatic birth experience have an impact on future reproduction? *British Journal of Obstetrics and Gynaecology*, 109, 254-260. doi: 10.1016/S1470-0328(02)01200-4
- Green, J., & Baston, H. (2003). Feeling in control during labor. Concepts, correlates, and consequences. *Birth*, 30, 235-247. doi: 10.1046/j.1523-536x.2003.00253.x

- Hauck, Y., Fenwick, J., Downie, J., & Butt, J. (2006). The influence of childbirth expectations on Western Australian women's perceptions of their birth experience. *Midwifery*, 23, 235-247. doi: 10.1016/j.midw.2006.02.002
- Herishanu-Gilutz, S., Shahar, G., Schattner, E., Kofman, O., & Holcberg, G. (2009). On becoming a first-time mother after emergency caesarean section. *Journal of Health Psychology*, 14, 967-981. doi:10.1177/1359105309341205
- Kershaw, K., Jolly, J., Bhabra, K., & Ford, J. (2005). Randomised controlled trial of community debriefing following operative delivery. *British Journal of Obstetrics and Gynaecology*, 112, 1504-1509. doi: 10.1111/j.1471-0528.2005.00723.x
- Koo, V., Lynch, J., & Cooper, S. (2003). Risk of postnatal depression after emergency delivery. *Journal of Obstetrics and Gynaecology Research*, 29, 246-250. doi: 10.1046/j.1341-8076.2003.00104.x
- Lanes, A., Kuk, J.L., & Tamim, H. (2011). Prevalence and characteristics of postpartum depression symptomatology among Canadian women: A cross-sectional study. *BMC Public Health*, 11, 302. doi: 10.1186/1471-2458-11-302
- Lapp, L., Agbokou, C., Peretti, C., & Ferreri, F. (2010). Management of post traumatic stress disorder after childbirth: A review. *Journal of Psychosomatic Obstetrics & Gynecology*, 31, 113-122. doi: 10.3109/0167482X.2010.503330
- Larsson, C., Saltvedt, S., Edman, G., Wiklund, I., & Andolf, E. (2011). Factors independently related to a negative birth experience for first-time mothers. *Sexual & Reproductive Healthcare*, 2, 83-89. doi: 10.1016/j.sshc.2010.11.003
- Levy, D.M. (2006). Emergency caesarian section: Best Practice. *Anaesthesia*, 61, 786-791. doi: 10.1111/j.1365-2044.2006.0411.x

Liu, S., Heaman, M., Joseph, K.S., Liston, R.M., Huang, L., Sauve, R., & Kramer, M.S.

for the Maternal Health Study Group of the Canadian Perinatal Surveillance System

(2005). Risk of maternal postpartum readmission associated with mode of delivery.

American Obstetrics and Gynecology, 105, 836-842. doi:

10.1097/01.AOG.0000154153.31193.2c

Lopez, K.A., & Willis, D.G. (2004). Descriptive versus interpretive phenomenology:

Their contributions to nursing knowledge. *Qualitative Health Research*, 14, 726-

735.

MaClean, L.I., McDermott, M.R., & May, C.P. (2000). Method of delivery and subjective

distress: Women's emotional responses to childbirth practices. *Journal of*

Reproductive and Infant Psychology, 18, 153-162.

<http://dx.doi.org/10.1080/0264683005008396>

Malacrida, C., & Bolton, T. (2013). The best laid plans? Women's choices, expectations

and experiences in childbirth. *Health*. Advance online publication.

doi:10.1177/1363459313476964

McGrath, K. (2007). Finding the path. *Journal of Perinatal Education*, 16(2), 7-15. doi:

10.1624/105812407X192415

Menage, J. (1993). Post-traumatic stress disorder in women who have undergone obstetric

and/or gynaecological procedures: A consecutive series of 30 cases of PTSD.

Journal of Reproductive and Infant Psychology, 11, 221-228. doi:

10.1080/02646839308403222

Merleau-Ponty (1962). *Phenomenology of perception*. London: Routledge & Kegan Paul.

- Millar, W.J., Nair, C., & Wadhera, S. (1996). Declining cesarean section rates: A continuing trend? *Health Reports*, 8, 17-24. Retrieved from <http://www.statcan.gc.ca/pub/82-003-x/4060784-eng.htm>
- Nakano, A., Ferreira, C., de Almeida, A., & Gomes, F. (2012). Childbirth experience according to a group of Brazilian primiparas. *Midwifery*, 28, e844-e849. doi: 10.1016/j.midw.2011.09.014
- Newfoundland and Labrador Centre for Health Information. (2011). *Live birth trends 2006-2010*. Retrieved from <http://www.nlchi.nl.ca/images/PDFs/Live%20Birth%20Trends%20%202006-2010%20Dec%205%202011.pdf>
- Nilsson, C., Bondas, T., & Lundgren, I. (2010) Previous birth experience in women with intense fear of childbirth. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 39, 298-309. doi: 10.1111/j.1552-6909.2010.01139
- Nilsson, C., Lundgren, I., Karlstrom, A., & Hildingsson, I. (2011). Self-reported fear of childbirth and its association with women's birth experience and mode of delivery: A longitudinal population-based study. *Women and Birth*, 25, 114-121. doi: 10.1016/j.wombi.2011.06.001
- Olson, J.E., Shu, X.O., Ross, J.A., Pendergrass, T., & Robinson, L.L. (1997). Medical record validation of maternally reported birth characteristics and pregnancy-related events: A report from the children's cancer group. *American Journal of Epidemiology*, 145, 58-67.

- Osterman, M.J.K., & Martin, J.A. (2013). Changes in cesarean delivery rates by gestational age: United States, 1996-2011. *NCHA Data Brief No. 124*. Retrieved from <http://www.cdc.gov/nchs/data/databriefs/db124.pdf>
- Patel, R.R., Murphy, D.J., & Peters, T.J. (2005). Operative delivery and postnatal depression: A cohort study. *British Medical Journal*, 330, 879. doi:10.1136/bmj.38376.603426.D3
- Reichert, J., Baron, M., & Fawcett, J. (1993). Changes in attitudes toward cesarean birth. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 22, 159-167. doi: 10.1111/j.1552-6909.1993.tb01795.x
- Ryding, E.L., Wijma, K., & Wijma, B. (1997). Posttraumatic stress reactions after emergency cesarean section. *Acta Obstetrica et Gynecologica Scandinavica*, 76, 856-861. doi: 10.3109/00016349709024365
- Ryding, E., Wijma, K., & Wijma, B. (1998a). Experiences of emergency cesarean section: A phenomenological study of 53 women. *Birth*, 25, 246-251. doi: 10.1046/j.1523-536X.1998.00246.x
- Ryding, E., Wijma, K., & Wijma, B. (1998b). Postpartum counseling after an emergency cesarean. *Clinical Psychology and Psychotherapy*, 5, 231-237. doi: 10.1002/(SICI)1099-0879(199812)5:4<231::AID-CPP172>3.0.CO;2-9
- Ryding, E., Wijma, K., & Wijma, B. (1998c). Predisposing psychological factors for posttraumatic stress reactions after emergency cesarean section. *Acta Obstetrica et Gynecologica Scandinavica*, 77, 351-352. doi: 10.1034/j.1600-0412.1998.770319.x

- Ryding, E., Wijma, K., & Wijma, B. (1998d). Psychological impact of emergency cesarean section in comparison with elective cesarean section, instrumental and normal vaginal delivery. *Journal of Psychosomatic Obstetrics & Gynecology*, *19*, 135-144. doi: 10.3109/01674829809025691
- Ryding, E., Wijma, K., & Wijma, B. (2000). Emergency cesarean section: 25 women's experiences. *Journal of Reproductive and Infant Psychology*, *18*(1), 33-39. doi: 10.1080/02646830050001663
- Ryding, E., Wiren, E., Johansson, G., Ceder, B., & Dahlstrom, A. (2004). Group counseling for mothers after emergency cesarean section: A randomized controlled trial of intervention. *Birth*, *31*, 247-253. doi: 10.1111/j.0730-7659.2004.00316.x
- Seguin, L., Therrien, R., Chapagne, F., & Larouche, D. (1989). The components of women's satisfaction with maternity care. *Birth*, *16*, 109-113. doi: 10.1111/j.1523-536x.1989.tb00878
- Sercekus, P., & Okumus, H. (2009). Fears associated with childbirth among nulliparous women in Turkey. *Midwifery*, *25*, 155-162. doi: 10.1016/j.midw.2007.02.005
- Sherwin, S. (1998). A relational approach to autonomy in health care. In The Feminist Health Care Ethics Research Network, Susan Sherwin Coordinator, *The politics of women's health: Exploring agency and autonomy* (pp. 19-47). Philadelphia: Temple University Press.
- Soet, J.E., Brack, G.A., & Dilorio, C. (2003). Prevalence and predictors of women's experience of psychological trauma during childbirth. *Birth*, *30*, 36-46. doi: 10.1046/j.1523-536X.2003.00215.x

- Somera, M., Feeley, N., & Ciofani, L. (2010). Women's experience of an emergency caesarean birth. *Journal of Clinical Nursing*, 19, 2824-2831. doi: 10.1111/j.13652702.2010.03230.x
- Stramrood, C.A.I., Paarlberg, K.M., Huis In't Veld, E.M.J., Berger, L.W.A., Vingerhoets, A.J.J., Schutz, W.C.M., & van Pampus, M.G. (2011). Posttraumatic stress following childbirth in homelike- and hospital settings. *Journal of Psychosomatic Obstetrics & Gynecology*, 27, 99-105. doi: 10.1080/01674820600714582
- Sword, W., Kurtz Landy, C., Thabane, L., Watt, S., Krueger, P., Farine, D., & Foster, G. (2011). Is mode of delivery associated with postpartum depression at 6 weeks: A prospective cohort study. *BJOG: An International Journal of Obstetrics and Gynaecology*, 118, 966-977. doi: 10.1111/j.1471-0528.2011.02950.x
- Tham, V., Christensson, K., & Ryding, E. (2007). Sense of coherence and symptoms of post-traumatic stress after emergency caesarean section. *Acta Obstetrica et Gynecologica Scandinavica*, 86, 1090-1096. doi: 10.1080/00016340701507693
- Tinti, C., Schmidt, S., & Businaro, N. (2011). Pain and emotions reported after childbirth and recalled 6 months later: The role of controllability. *Journal of Psychosomatic Obstetrics and Gynaecology*, 32, 98-103. doi: 10.3109/0167482X.2011.557756
- van Manen, M. (1990). *Researching lived experience: Human science for an action sensitive pedagogy* (2nd ed.). London: The Althouse Press.
- Waldenstrom, U. (1999). Experience of labor and birth in 1111 women. *Journal of Psychosomatic Research*, 47, 471-482. [http://dx.doi.org.qc2a-proxy.mun.ca/10.1016/S0022-3999\(99\)00043-4](http://dx.doi.org.qc2a-proxy.mun.ca/10.1016/S0022-3999(99)00043-4)

Waldenstrom, U., Borg, I.M., Olsson, B., Skold, M., & Wall, S. (1996). The childbirth experience: A study of 295 new mothers. *Birth*, 23, 144-153. doi:10.1111/j.1523-536X.1996.tb00475.x

Waldenstrom, U., Hildingsson, I., & Ryding, E. (2006). Antenatal fear of childbirth and its association with subsequent caesarean section and experience of childbirth. *British Journal of Obstetrics and Gynaecology*, 113, 638-646. doi: 10.1111/j.1471-0528.2006.00950.x

Waldenstrom, U., Hildingsson, I., Rubertsson, C., & Radestad, I. (2004). A negative birth experience: Prevalence and risk factors in a national sample. *Birth*, 31, 17-27. doi: 10.1111/j.0730-7659.2004.0270.x.

Wijma, K., Ryding, E.L., & Wijma, B. (2002). Predicting psychological well-being after emergency caesarean section: A preliminary study. *Journal of Reproductive and Infant Psychology*, 20, 25-36. doi: 10.1080/02646830220106776

Wijma, K., Soderquist, J., & Wijma, B. (1997). Posttraumatic stress disorder after childbirth: A cross sectional study. *Journal of Anxiety Disorders*, 11, 587-597.
[http://dx.doi.org.qe2a-proxy.mun.ca/10.1016/50887-6185\(97\)00041-8](http://dx.doi.org.qe2a-proxy.mun.ca/10.1016/50887-6185(97)00041-8)

Yokote, N. (2008). Women's experiences of labor, surgery and first postnatal week by an emergency cesarean section. *Journal of Japan Academy of Midwifery*, 22, 37-48.

Appendix A: Information Sheet for Public Health Nurses

The Experiences of Women Who Undergo Emergency Cesarean Section: A Phenomenological Study

Study Description for Public Health Nurses-Eastern Health

This qualitative study will explore the experiences of women who have undergone an emergency cesarean section (EmCS). An EmCS, for the purposes of this study, is one that is performed in an obstetric emergency, where complications of pregnancy onset suddenly during the process of labor and swift action (decision to incision time ≤ 30 minutes) is required to prevent the deaths of mother, child(ren) or both. Recent statistics released by the Newfoundland and Labrador Centre for Health Information indicate that the cesarean section rate for Newfoundland and Labrador for 2010 was at 33%. The number of EmCS is unknown. This research will help us explore and better understand what the experience of an EmCS is like for the women who have gone through it. Study findings have the potential to create awareness and better understanding of the experience and possibly facilitate health care workers to better meet the needs of these women.

I am asking you as a public health nurse in Eastern Health to assist me with participant recruitment. If you could screen all new Live Birth Notifications as well as any other clients that you are following who meet the study inclusion criteria (please see below) and inform the potential participant that there is a study being conducted on the experiences of women who undergo EmCS. If these women are interested in participating or they would like further information they can contact me, Julie Sullivan, for further details. Each woman will be asked to have a conversation with me where she will

describe what the EmCS experience was like for her. I will give each participant a \$25 gift card from Walmart as a token of appreciation for her time in assisting with this research study.

Inclusion Criteria:

1. Had an EmCS within 12 months of recruitment into the study
2. Given birth to a live, healthy newborn
3. 19 years of age or older
4. Speaks English
5. Has a telephone

Exclusion Criteria:

1. Outcome of childbirth is a newborn with a disability or perinatal loss during EmCS
2. History of a psychiatric illness prior to or following an EmCS
3. History of or current substance abuser
4. < 19 years of age

I would like to interview approximately 10-12 women who meet the criteria. The final report will be presented at the Memorial University School of Nursing Research Day. I will inform all public health nurses of presentation dates. If you have any further questions or require clarification of any of the study details, please do not hesitate to call me. Your assistance and consideration is greatly appreciated.

Thank you,

Julie Sullivan

709-334-3896
709-363-7407

Can call collect

Appendix C: Guiding Questions for Interview

The main question that will be asked of the participants in my study is as follows:

1. Could you please tell me about your experience with having your emergency cesarean section?

The others are possible questions that I may use depending on where the conversation leads:

2. Can you recall the events leading up to you having your emergency cesarean section?
3. Were you made aware of the reason(s) why you had to have an emergency cesarean section?
4. What were your expectations of pregnancy and childbirth heading into this experience?
5. What things/people made you feel more at ease during the whole process?
6. What things/people made you feel less at ease (or upset)?
7. What were your initial thoughts when you were told you would have to have an emergency cesarean section?
8. How did you prepare yourself?
9. How much time passed from the first time you were told you would need to have the cesarean until you actually went to the operating room?
10. What were your thoughts as you were being prepared for surgery?
11. What were your concerns about yourself? Your baby?
12. What were your thoughts when you held your healthy newborn safely in your arms?

13. Did you feel supported by the nursing staff throughout the whole experience?
14. Do you feel as though your needs were met?
15. What do you think would have made the whole experience better for you?

Appendix D: Informed Consent

Consent to Take Part in Research

TITLE: The experiences of women who undergo an emergency cesarean section: A phenomenological study.

INVESTIGATOR(S): Julie Sullivan, BN, RN, Master of Nursing student at Memorial University.

You have been invited to take part in a research study. Taking part in this study is voluntary. It is up to you to decide whether to be in the study or not. You can decide not to take part in the study. If you decide to take part, you are free to leave at any time. *This will not affect your usual health care/normal treatment.*

Before you decide, you need to understand what the study is for, what risks you might take and what benefits you might receive. This consent form explains the study.

Please read this carefully. Take as much time as you like. If you like, take it home to think about for a while. Mark anything you do not understand, or want explained better. After you have read it, please ask questions about anything that is not clear.

The researchers will:

- discuss the study with you
- answer your questions
- keep confidential any information which could identify you personally
- be available during the study to deal with problems and answer questions

1. Introduction/Background:

You are being asked to participate in a study that will explore the experiences of women who undergo an emergency cesarean section. Your participation in this study will provide a more accurate understanding of what this experience means for the woman and what type of additional, if any, support is necessary.

04/30/2012

Participant Initials _____

2. Purpose of study:

To explore the experiences of women who undergo an emergency cesarean section.

3. Description of the study procedures:

You will be asked to participate in an interview within 12 months of having an emergency cesarean section. The interview will occur at a time and place that is most convenient for you. The interview will be tape recorded with your permission, and will be transcribed word for word in order to help remember the conversation. During the interview, I will ask you to describe your experience with having an emergency c-section. I will ask you to reflect on the events leading up to your having an emergency c-section and to recall your feelings throughout the experience.

4. Length of time:

The interview is expected to last anywhere from 60-90 minutes. I will also contact you by telephone after I have read through the interview to check that my understanding of the experience of an emergency cesarean is a good understanding. This will take approximately 15 minutes.

5. Possible risks and discomforts:

I do not anticipate any risk to you in taking part in this study. However, if during the interview the memories of your cesarean section cause any form of distress, I will stop the interview and let you decide if you wish to continue. If it would help you, I can contact a support person for you with your permission. Also, I can provide you with the Mental Health Crisis Line contact information.

6. Benefits:

It is not known whether this study will benefit you.

7. Liability statement:

Signing this form gives us your consent to be in this study. It tells us that you understand the information about the research study. When you sign this form, you do not give up your legal rights. Researchers or agencies involved in this research study still have their legal and professional responsibilities.

8. What about my privacy and confidentiality?

Protecting your privacy is an important part of this study. Every effort to protect your privacy will be made. However it cannot be guaranteed. For example we may be required by law to allow access to research records.

When you sign this consent form you give us permission to

- Collect information from you
- Share information with the people conducting the study
- Share information with the people responsible for protecting your safety

Access to records

The members of the research team will see study records that identify you by name. Other people may need to look at the study records that identify you by name. This might include the research ethics board. You may ask to see the list of these people. They can look at your records only when supervised by a member of the research team.

Use of your study information

The research team will collect and use only the information they need for this research study.

This information will include your

- date of birth
- information from study interviews and questionnaires

Your name and contact information will be kept secure by the research team in Newfoundland and Labrador. It will not be shared with others without your permission. Your name will not appear in any report or article published as a result of this study.

Information collected for this study will be kept for five years.

If you decide to withdraw from the study, the information collected up to that time will continue to be used by the research team. It may not be removed. This information will only be used for the purposes of this study.

After your part in this study ends, we may continue to review your health records to check that the information we collected is correct.

Information collected and used by the research team will be stored in the researcher's office in a locked cabinet to which only the researcher will have access to.

Your access to records

You may ask the *researcher* to see the information that has been collected about you.

9. Questions or problems:

If you have any questions about taking part in this study, you can meet with the investigator who is in charge of the study at this institution. That person is: Julie Sullivan

Julie Sullivan (709)334-3896 (h), or (709)363-7407 (c)

My research supervisors are:

04/30/2012

Participant Initials _____

Dr. Shirley Solberg, Memorial University of Newfoundland School of Nursing, 709-777-8083

Dr. Cindy Murray, Memorial University of Newfoundland School of Nursing, 709-777-8311

Or you can talk to someone who is not involved with the study at all, but can advise you on your rights as a participant in a research study. This person can be reached through:

Ethics Office
Health Research Ethics Authority
709-777-6974 or by email at info@hrea.ca

After signing this consent you will be given a copy.

04/30/2012

Participant Initials _____

Signature Page

Study title: The experiences of women who undergo an emergency cesarean section: A phenomenological study.

Name of principal investigator: Julie Sullivan, BN, RN

To be filled out and signed by the participant:

Please check as appropriate:

I have read the consent.	Yes { } No { }
I have had the opportunity to ask questions/to discuss this study.	Yes { } No { }
I have received satisfactory answers to all of my questions.	Yes { } No { }
I have received enough information about the study.	Yes { } No { }
I have spoken to Mrs. Julie Sullivan and he/she has answered my questions	Yes { } No { }
I understand that I am free to withdraw from the study	Yes { } No { }
<ul style="list-style-type: none"> • at any time • without having to give a reason • without affecting my future care 	
I understand that it is my choice to be in the study and that I may not benefit.	Yes { } No { }
I understand how my privacy is protected and my records kept confidential	Yes { } No { }
<i>I agree to be audio taped</i>	Yes { } No { }
I agree to take part in this study.	Yes { } No { }

Signature of participant

Name printed

Year Month Day

To be signed by the investigator or person obtaining consent

04/30/2012

Participant Initials _____

I have explained this study to the best of my ability. I invited questions and gave answers. I believe that the participant fully understands what is involved in being in the study, any potential risks of the study and that he or she has freely chosen to be in the study.

Signature of investigator

Name printed

Year Month Day

Telephone number: _____

04/30/2012

Participant Initials _____

Appendix E: Socio-demographic Information

Pseudonym: _____

Q1. Age _____

Q2. What is your marital status?

Single_____ Married_____ Divorced _____ Separated_____

Q3. How many children do you have? _____

Q4. How old is your baby? _____

Q5. What is your employment status?

Full time employed_____

Part time employed_____

Self-employed_____

Housewife_____

Unemployed_____

Q6. What is your highest level of education?

Elementary school_____

High school_____

College/University_____

Graduate school_____

Appendix F: HREA Ethical Approval



Ethics Office
Suite 200, Eastern Trust Building
95 Bonaventure Avenue
St. John's, NL
A1B 2X5

May 1, 2012

Mrs. Julie Sullivan
 PO Box 405
 Bay Bulls, NL A0A 1C0

Dear Mrs. Sullivan:

Reference # 12.078

RE: The experiences of women who undergo an emergency cesarean section: A phenomenological study

We will acknowledge receipt of your correspondence dated April 24, 2012.

This correspondence has been reviewed by the Chair under the direction of the Board. **Full board approval** of this research study is granted for one year effective **April 19, 2012**.

This is to confirm that the Health Research Ethics Board reviewed and approved or acknowledged the following documents (as indicated):

- Revised consent form, dated April 30, 2012
- Revised information sheet
- Poster

MARK THE DATE

This approval will lapse on **April 18, 2013**. It is your responsibility to ensure that the Ethics Renewal form is forwarded to the HREB office prior to the renewal date. *The information provided in this form must be current to the time of submission and submitted to HREB not less than 30 nor more than 45 days of the anniversary of your approval date.* The Ethics Renewal form can be downloaded from the HREB website <http://www.hrea.ca>.

The Health Research Ethics Board advises THAT IF YOU DO NOT return the completed Ethics Renewal form prior to date of renewal:

- Your ethics approval will lapse
- You will be required to stop research activity immediately

email: info@hrea.ca

Phone: 777-8949

FAX: 777-8776

Mrs. J. Sullivan
Reference #12.76
May 1, 2012

Page 2

- *You may not be permitted to restart the study until you reapply for and receive approval to undertake the study again*

Lapse in ethics approval may result in interruption or termination of funding

It is your responsibility to seek the necessary approval from the Regional Health Authority or other organization as appropriate.

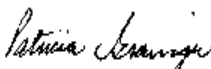
Modifications of the protocol/consent are not permitted without prior approval from the Health Research Ethics Board. Implementing changes in the protocol/consent without HREB approval may result in the approval of your research study being revoked, necessitating cessation of all related research activity. Request for modification to the protocol/consent must be outlined on an amendment form (available on the HREB website) and submitted to the HREB for review.

This research ethics board (the HREB) has reviewed and approved the research protocol and documentation as noted above for the study which is to be conducted by you as the qualified investigator named above at the specified site. This approval and the views of this Research Ethics Board have been documented in writing. In addition, please be advised that the Health Research Ethics Board currently operates according to *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans; ICH Guidance 16: Good Clinical Practice* and applicable laws and regulations. The membership of this research ethics board is constituted in compliance with the membership requirements for research ethics boards as defined by *Health Canada Food and Drug Regulations Division 5; Part C*.

Notwithstanding the approval of the HREB, the primary responsibility for the ethical conduct of the investigation remains with you.

We wish you every success with your study.

Sincerely,



Patricia Grainger, Acting Chair
Health Research Ethics Board

C.C. VP Research c/o Office of Research, MUN
VP Research c/o Pulicni Research Centre, Eastern Health
HREB meeting date: May 17, 2012

Email: info@hrec.ca

Phone: 777-8949

FAX: 777-8116