Stress responses experienced by a group of mothers who gave birth by unplanned Caesarean section

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ABSTRACT
The present study aimed to explore the nature of stress responses experienced by women during birth by unplanned Caesarean section. Research suggests that the psychological effects of birth can be significant and stressful for some women. The events occurring during a traumatic birth experience could affect a woman’s emotional and psychological state, which could generate potentially virulent stress reactions. In-depth interviews were undertaken in 2010 to explore 10 women’s lived experiences and meanings of birth. This interpretive phenomenological study aimed to gain a greater understanding of how women perceive and internalise their childbirth experiences. Thematic content analysis was used to synthesise data. The principles of phenomenological theory served as a broad framework for the structuring, organisation and categorising of data. The stress responses experienced by women both prior to, and during the Caesarean section were predominantly anxiety-based, whereas they reported more depressive symptoms in the post-partum period. The experience of adverse emotional consequences during the post-partum period can undermine a woman’s ability to successfully adapt to her role as a mother, meet the needs of her infant, and cope with post-partum challenges.

Keywords: anxiety; birth; post-partum depression; emotional responses; interpretive phenomenological analysis; stress; unplanned Caesarean section

Childbearing has been acknowledged as a major life transition for women, with the actual birth being the climax of this process (Darvill, Skirton, & Farrand, 2008).
The impact of an unexpected Caesarean delivery on this experience has begun receiving more attention in recent years (Weiss, Fawcett, & Aber, 2009). For women who desire to deliver their babies naturally, a birth culminating in an unplanned Caesarean section may colour and complicate their labour experiences, as well as their adaptive transition to motherhood (Fenwick, Gamble, & Hauck, 2007; Nystedt, Hogberg, & Lundman, 2008). Existing literature on the topic persistently documents negative psychological and emotional responses to Caesarean delivery among women (Lobel & DeLuca, 2007; Stadlmayr, Schneider, Amsler, Burgin, & Bitzer, 2004; Weiss et al., 2009), as well as the potentially virulent stress reactions generated by such powerful emotions (Gamble & Creedy, 2005; Olde, van der Hart, Kleber, & van Son, 2006). Recently these emotional reactions have been described as post-traumatic stress responses (Gamble & Creedy, 2005; Tham, Christensson, & Ryding, 2007), and have been associated with negative perceptions of the birth, self and infant; poor parenting behaviours; and an increased risk for postpartum mood disorders (Lobel & DeLuca, 2007).

BACKGROUND AND MOTIVATION

Stress is described as an event in which an organism senses a threatening or real disruption of homeostasis, and which leads to a compensatory reaction (Goldstein & McEwen, 2002). In simple terms, the stress paradigm suggests that a stressor will lead to certain outcomes (Wheaton & Montazer, 2009).

Stressors refer to the problems, hardships or threats that challenge the adaptive capacities of individuals, and comprises both external stimuli and the perceptual processes of the individual (Cohen, Kessler, & Gordon, 1995). According to the American Psychiatric Association (2000), a traumatic event happens suddenly and unexpectedly, threatens one’s sense of control, and disrupts one’s beliefs, values, and basic assumptions. This type of event is acknowledged as psychologically distressing; one that has the potential to overcome a person’s normal ability to cope. This definition may well apply to what some women experience during an unexpected labour and birth process, such as in an unplanned Caesarean section (Darvill et al., 2008; Olde et al., 2006).

Cox and Griffiths (1995) identify three approaches in the conceptualisation of the nature of stress. First, is the engineering approach, where stress is viewed as a stimulus or characteristic of the environment in the form of level of demand. Second, is the physiological approach, where the definition of stress is based upon the physiological or biological changes that occur in the person when they are in a stress state. Third, the psychological approach conceives of stress not as a mere stimulus or response, but rather as a dynamic process that occurs as an individual interacts with their environment.

A distinction is made between two types of psychological models of stress: interactional or structural approaches, and transactional or process models
STRESS RESPONSES EXPERIENCED BY A GROUP OF MOTHERS

(Fruzzetti & Worrall, 2010). Cox, Griffiths, and Rial-Gonzalez (2000) explain that interactional models focus on the structural characteristics of the stress process; that is, which stressors are likely to lead to which outcomes in which populations. Alternatively, transactional views are more cognitive, and focus on the dynamic results of the interactions between individuals and their environments. The physical risk present in a Caesarean section, together with the angst of the situation, results in stress hormones flooding through the bodies of both mother and baby. This has been acknowledged to set up a dynamic and transactional effect of potential physiological and psychological stress responses in women during the actual birth process (Fenwick, Holloway, & Alexander, 2009).

The possible emotional distress evoked in this process, and its ensuing consequences, have further been acknowledged to potentially hinder the series of necessary psychological adjustments that subsequently need to be made in the post-partum period (Fenwick et al., 2009; Roux & van Rensburg, 2011). In terms of transactional theory, outcomes of a traumatic and distressing birth experience have therefore been identified as the physical, behavioural, and psychological products of this dynamic process and include such diverse responses as anxiety and depression (Griffin & Clark, 2011; Ryding, Wijma, & Wijma, 2000).

Transactional models of stress are founded on the common observation that although some events are intrinsically stressful, individuals respond to stressful events in several different ways (Fruzzetti & Worrall, 2010). Given the many interrelated levels of psychological and physiological functioning, there is no reason to suppose that stress will be expressed in only one way or at only one of these levels (Wheaton, 2009). Transactional views therefore place emphasis on the role of subjective perceptions of the environment, and acknowledge the possible impact of individual difference factors (Cox et al., 2000; Fruzzetti & Worrall, 2010).

Transactional theory research leaves little doubt that the stress process can be inimical to health and well-being, and that it can manifest negative effects in many ways at multiple levels of organismic functioning (Wheaton, 2009). A wide variety of physical and mental states have been identified as possible consequences of the stress process, with some of the most significant being that of emotional trauma, distress, and adverse emotional outcomes (Fruzzetti & Worrall, 2010). Research into birth and labour experiences supports this theory and acknowledges that adverse childbirth experiences related to unexpected medical intervention, such as an unplanned Caesarean section, can potentially evoke diagnostically significant post-traumatic emotional stress responses in women (Rowe-Murray & Fisher, 2001; Ryding et al., 2000). Research findings suggest that these responses can even include acute traumatic stress reactions (Alder, Stadlmayr, Tschudin, & Bitzer, 2006; Ayers, 2007; Ryding et al., 2000), post-partum ‘baby blues’ or depressive mood disturbances (Lobel & DeLuca, 2007; Noriko, Mequmi, Hanako, & Yasuko, 2007; Robertson, Grace, Wallington, & Stewart, 2004), grief (Nystedt et al., 2008; Olde et al., 2006; Ryding et al., 2000), or a combination of these.
A literature review revealed that there is currently no existing published research on the nature of stress responses experienced by South African women who delivered their infants by unplanned Caesarean section. This study therefore aimed to explore the nature of stress responses experienced by a group of women as a result of their unexpected labour and birth experiences.

**RESEARCH DESIGN**

An exploratory research design was used to explore and describe the nature of stress experienced by women during birth by unplanned Caesarean section. Qualitative research examines the lived experience in an effort to describe, explain, understand, and give meaning to peoples’ experiences, behaviours, interactions and social contexts (Davidson, 2002; Fossey, Harvey, McDermott, 2002, & Strauss & Corbin, 1998). Within qualitative research, phenomenology refers to the individual’s personal construction of the meaning of a phenomenon (Mertens, 2009). Original data are comprised of ‘naive’ descriptions obtained through open-ended questions and dialogue, and the researcher describes the structure of the experience based on reflection and interpretation of the participant’s story (Moustakas, 1994). Such an approach places this study within the interpretive phenomenological perspective. The researcher explored in detail how mothers made sense of the stress that they experienced during their unplanned Caesarean deliveries with the intention of understanding their meaning, while simultaneously interpreting how themes of meaning are structured.

**Research Methods**

The research began with ensuring ethically sound research, followed by data collection and analysis. Throughout the study, trustworthiness of the research findings was emphasised.

**Ethical Considerations**

Ethical issues and standards were critically considered. In accordance with the ethical rules of conduct for practitioners registered under the Health Professions Act of South Africa, 1974 (Health Professional Council of South Africa, Professional Board for Psychology, 2004), several measures were taken to ensure the ethicality of this research. First, the research protocol was approved by the relevant ethics committee. Thereafter, prospective participants were informed of the background to the study and the voluntary nature of participation in the study. Interviews proceeded once participants had given verbal and written consent. The researcher was fully aware of the sensitive and emotional nature of exploratory inquiry, and the rights and needs of the individual were therefore considered at all times. Furthermore,
the participants were assured of confidentiality. Finally, participants were debriefed at the resolution of the interview process by a clinical psychologist to resolve any questions, unease or queries.

**Population and Sampling**

Phenomenology uses purposive, non-probability sampling procedures, where participants are included because they have a specific knowledge of the phenomena (Baker, Wuest & Stern, 1992). For the purposes of this study, an *unplanned Caesarean section* referred to a surgical, Caesarean delivery, despite the mother’s desire to deliver her baby naturally. Such a delivery may have occurred after labour had begun due to unexpected maternal or foetal conditions, or prior to labour, as is the case in an emergency Caesarean delivery. Thus, in this study, the population of interest comprised mothers who had wanted to deliver their babies naturally, but who had instead had to deliver their babies by Caesarean section. Within the population of interest, participants were selected according to the following criteria:

- Married women: The levels of support received from a spouse have been acknowledged to be a mediator of the impact of stress (Simons, Lorenz, Wu, & Conger, 1993).
- Mothers aged 25 to 30 years.
- It was the birth of each woman’s first-born child that culminated in a Caesarean delivery: After any type of Caesarean delivery, a mother’s subsequent children are likely to be born by elective Caesarean delivery. It could therefore only be the birth of a first baby for which a mother prepares to deliver naturally, but for whatever reason was required to have an unplanned Caesarean section.
- A period of two to four years had elapsed since each woman’s unplanned Caesarean delivery: Immediately after the birth, a woman’s perceptions, experiences, and indeed subjective accounts may be influenced by post-partum emotional disturbances.
- Caucasian women: Cultural beliefs about and values associated with childbearing touch all aspects of social life in any given culture. Such beliefs and values could lend different perspectives to the meaning of childbirth to the childbearing woman (Callister, 2006).
- No previous miscarriages have been experienced: The possible emotional responses to a miscarriage may influence a mother’s feelings and experiences of subsequent pregnancies, as well effect perceived levels of coping and resiliency (Klier, Geller, & Ritsher, 2002).

Selection of participants included snowball sampling, as discussed by Babbie (2007), where women nominated acquaintances whom they thought may be willing to participate in the research. The sample comprised ten women, with a mean age of 28 years, who volunteered for in-depth phenomenological semi-structured interviews. Interviews were not limited to a certain number, but continued until data saturation...
had taken place in order to deepen, enrich and complete categories, themes and concepts (Brink & Wood, 2001).

**Data Collection**

Various aspects were explored in in-depth phenomenological interviews, allowing the researcher to probe certain aspects offered by participants in order to understand and explore their contributions in as much depth as possible. A semi-structured, open-ended approach allowed for the exploration of relevant opinions, perceptions, feelings, and comments in relation to the women’s experiences.

**Data Analysis**

Thematic content analysis allows for detailed analysis of data (Nystedt et al., 2008). When it comes to analysis, phenomenological researchers engage in active and sustained reflection as they ‘dwell’ with the data and interrogate the content. By applying the analytical method as suggested by Wertz (1983) and Giorgi (1985), analysis involved systematic readings of the transcripts and field notes by first dwelling on the phenomenon (through empathetic immersion and reflection), and then describing emergent psychological structures (i.e., constituents and recurrent themes). Analysis continued with a cross-category search to identify recurring regularities expressed as themes that were seen at an interpretive level as underlying threads of meaning running through condensed meaning units, codes, or categories (Graneheim & Lundman, 2004). Themes were then categorised so that data could be synthesized and comparisons could take place.

**Measures to Ensure Trustworthiness**

To ensure trustworthiness of findings, Guba’s model from 1985 of trustworthiness of qualitative research data were applied to this study (Lincoln & Guba, 1985). The model identifies four aspects of enhanced trustworthiness of a study, namely, credibility, transferability, confirmability, and dependability.

To enhance credibility, the researcher engaged in active and sustained reflection during data interpretation to ensure quality, and to highlight the complexity of participants’ experiences (Marshall & Rossmann, 1995). The researcher aimed to suspend previous assumptions in order to be open to the phenomenon as it appeared, and to generate a sense of reality and a personal recognition of the phenomenon through precise and rich description. This refers to the extent to which the findings are a function solely of the research participants and conditions of the research, with no biases, motivations and researchers’ perceptions (Krefting, 1991).

Transferability was achieved through thorough description of the research context and the assumptions that were central to the research. The criteria applied were made explicit, according to the purpose and orientation of the study (Patton, 2002).
To ensure confirmability in this study, the researcher and an external auditor reached agreement that the findings, conclusions and recommendations made by the researcher were supported by the data and that the researcher’s interpretation of the data was meaningful and relevant.

Dependability was achieved through clear and thorough description of methods used in gathering, analysis and interpretation of data, as well as in the precise and comprehensive reporting of data. Documentation was such that other researchers would be able to follow the investigative process and reach similar conclusions given the researcher’s data, perspective and situation (Marshall & Rossman, 1995).

FINDINGS

Thematic content analysis gave rise to the identification of the themes relevant to exploring the nature of stress responses experienced by women in relation to unplanned Caesarean sections. Three distinct phases/categories of women’s stress experiences were identified, being stress experienced prior to the Caesarean, stress experienced during the Caesarean, and stress experienced post-Caesarean. The data held within these themes were analysed into discrete parts; concepts relevant in developing a deeper understanding of women’s experiences. The categories are named and explained below, indicating and discussing the concepts that have been connected/grouped within each category.

Stress Experienced Prior to the Caesarean

The majority of the women experienced a trial of labour before a Caesarean section became necessary. However, due to complications or physical limitations, labour later became prolonged and difficult. In these cases, women described the pain as just unbelievable, it was just incredible (Mom #10). The labouring period was considered a physically gruelling experience; one that left mothers tired [and] so exhausted (Mom #4). Furthermore, lengthy labouring without progression became reason for them to be concerned: Nothing was happening . . . (Mom #3), and I started to worry . . . why is this not going the way it’s supposed to, you don’t understand what is going on (Mom #4).

The identification of a medical complication was extremely anxiety-provoking for women. Mom #3 explained: They say ‘emergency Caesar’ and you immediately think something is wrong with the baby. For some of the mothers, the uncertainty that they experienced included significant concern about whether their babies were still going to live through all of this (Mom #9). Mom #8 explained, saying: I started freaking out, all I could think was you need to get baby out within 5 minutes or baby is going to die.

Once the decision to perform a Caesarean section had been made, six of the women described the ensuing events as complete and utter chaos (Mom #8). This
contributed to a sense of bewilderment: *It just felt like everything was just going so fast, all rushing past me so quickly. And there was nothing I could do to stop it. I was just lost in it* (Mom #10). Consequently, in the commotion that accompanied a Caesarean delivery, women were left feeling disorientated, uncertain and insecure: *Nurses would rush past me and they wouldn’t tell me where I was or where they were taking me... I mean, they probably thought that I was supposed to know but I didn’t* (Mom #6). Mom #7 explained that: *It’s so confusing, you don’t know if this is normal or if this should be happening.* With little time to prepare mentally for the operation, not knowing what to expect fostered a sense of panic and feelings of helplessness.

**Stress Experienced During the Caesarean**

Mothers’ emotional reactions during the surgery were susceptible to the influence of medical staff’s conduct. The women described staff’s reactions and management of the Caesarean section as frantic. They became concerned in response to the atmosphere of alarm, with their distress pertaining to a sense of emergency: *I started freaking out... nothing was controlled, everyone seemed to be in a panic*” (Mom #8). Mom #2 further explained that: *I heard them shouting to each other to hurry up, so it was a bit panicky, which made me a bit panicky... It was very frightening*. During preparation for surgery, mothers recounted how you just lie there like a turkey being basted (Mom #7). This left them feeling vulnerable and very exposed (Mom #4). Surgery itself was detailed as a procedure whereby doctors [cut] you up like they’re going to serve you for dinner (Mom 3).

Some women were critical of inadequate communication during the labour period, as it was perceived as contributing to a sense of insecurity and uncertainty: *I was feeling very vulnerable and very exposed... I could feel them working on me and I could feel that things were happening, but no one was telling me what they were doing, what was going on...* (Mom #4). Mom #6 further explained that *nurses would rush past me and they wouldn’t tell me where I was or where they were taking me. I was just so frustrated*. Mothers were left feeling excluded, dismissed and insignificant.

**Stress Experienced Post-Caesarean**

Immediately post-Caesarean, the women in this study reported their initial contact with their babies to have been delayed. In most cases, this was due to routine Caesarean procedure: *So baby doesn’t come straight to mom... they do that, they take baby away to check. There was that distance, that separation...* (Mom #1). For those mothers not prepared for it, this was described as distressing: *I didn’t know where my baby was and it made me nervous* (Mom #6). Mom #4 further explained that *I just wanted my baby, they had him in the nursery and I couldn’t get to him. It was horrible*. This separation was anxiety-provoking for women, and prolonged the distress experienced throughout the labour and operative process.
During the actual Caesarean procedure anaesthesia numbed the pain, but once the medication had worn off post-Caesarean, mothers described a period of intense physical trauma (Mom #7). For the women in this study, heightened somatic stress reactions in response to having an unplanned Caesarean section, together with the pain and fatigue that resulted from having a major operation, contributed to a strenuous and wearing initial post-partum period: I was tired, I was so exhausted... I had nothing left (Mom #6). The subsequent prolonged and painful recovery period was extremely taxing for women, primarily because they almost didn’t even have the energy to care (Mom #4). Furthermore, mothers reported having pains in my shoulders, I was tender, I was bruised, I felt like I couldn’t breathe properly (Mom #8). This period was frustrating for mothers as they physically struggled to care for their newborns.

For these women, the desire to have a natural birth encompassed the idea of the baby coming out through the canal, and the closeness; the bond that you form then in that process (Mom #1). After having a Caesarean delivery, mothers felt robbed of an intimate birth experience: It was taken away from me (Mom #2). Feelings of regret were experienced when the birthing experience was not what had been anticipated. As Mom #4 explained, It didn’t go the way I had wanted it to go, the way I had prepared for. It wasn’t what I had been dreaming of, and the thoughts, or feelings, weren’t what I had imagined them to be. It wasn’t what I had wanted. Feelings of disappointment were primarily associated with unmet expectations; that is, the experience had not been what women had hoped and planned for.

For some mothers, a Caesarean delivery represented a failure on their part: I failed to be able to give birth naturally... I sometimes blame myself for not pushing harder (Mom #5). The disappointment of an unsuccessful natural delivery led to self-doubt and feelings of regret. This resulted in women wondering what have I done wrong? (Mom #1), and questioning their abilities as both women and mothers: I thought I had failed myself and womankind as a whole (Mom #3).

Some women experienced significant emotional disturbance in the post-partum period. Mothers described how the whole thing was so draining... I was finished, mentally and physically (Mom #4). The delivery experience was described as an emotional rollercoaster (Mom #9), and was associated with emotions such as sadness, disappointment, anxiety and grief in the post-partum period.

The mothers reported some depressive symptoms. These included psychomotor retardation, a decreased interest in normal activities, irritability and anger, disturbed sleeping patterns, reduced concentration levels, fatigue, low energy levels, feelings of worthlessness or guilt, and persistent sadness. Mom #8 explained how she...just cried and cried. I really battle... and Mom #10 agreed, saying: I should’ve been happy but I was just crying for so long and no one knew why... I just really, really battled.
Some mothers reported traumatic stress reactions during the post-partum period. Symptoms included a sense of emotional numbness, such as an absence of relation to the baby, avoidance of things related to the birth, such as the baby, and heightened levels of arousal, such as insomnia and anxiety about the baby’s health: *Afterwards, I was extremely scared to even go to sleep and to leave the child alone. For the first couple of nights I didn’t sleep. I was just too scared that something was going to happen* (Mom #8).

Symptoms of grief after the unplanned Caesarean section included sadness, anger, and guilt. As Mom #7 explained:

*Thinking about my first child and that whole period, I can only think about the horrible stuff and everything that went wrong, rather than the time with this new baby in the house, and all that nice stuff ... Walking her, carrying her, moving, sitting, coughing, sneezing, laughing, was all stuff that I now couldn’t do.*

**DISCUSSION**

In this study, an unplanned Caesarean section was described as a distressing, difficult and disappointing experience for women; one that confronted mothers with considerable adjustment difficulties. Consequently, women reported several uncomfortable stress responses. The nature of the stress responses reportedly experienced by women both prior to, and during the Caesarean section was predominantly anxiety-based, whereas they reported more depressive stress responses and symptoms in the post-partum period.

Before and during the Caesarean section, women described feelings of anxiety. Research suggests that women’s feelings of confidence and security quickly change to ones of fear and anxiety when they learn that they are going to have a Caesarean section (Berg & Dahlberg, 1998; Ryding et al., 2000). Culmination of the birth in a Caesarean section has been acknowledged as potentially anxiety-provoking for women who felt unprepared and had little knowledge of the processes involved (Barclay, Everitt, Rogan, Schmied, & Wyllie, 1997; Lavender, Walkinshaw, & Walton, 1999; Nelson, 2003). Elements of labour and delivery may then be unexpected and frightening, potentially eliciting traumatic stress responses (Soderquist, Wijma, & Wijma, 2002).

Anxiety-provoking aspects of the unplanned Caesarean section included physical complications and pain for the women in this study. Research suggests that the presence of physical pressures can modify the psychological impact of childbirth (Clement, 2001; Karlstrom, Engstrom-Olfsson, Norbergh, Sjoling, & Hildingsson, 2007), where physical distress increases the risk of a negative and stressful birth experience (Stadlmayr et al., 2004). Furthermore, women’s privacy and sense of physical integrity is compromised by their dependence on physicians, a loss of autonomy, feelings of depersonalisation, and perceptions of insensitive physical
invasion (Ford & Ayers, 2011; Olde et al., 2006; Roux & van Rensburg, 2011). Thus, women’s privacy was perceived to have been compromised and they were left feeling uneasy and uncomfortable.

Treatment by hospital staff during the labour and birth process has been acknowledged as influential in the experience and appraisal of the birth (Clement, 2001; Darvill et al., 2008; Ryding et al., 2000). In this study, women were critical of inadequate communication by staff. As mothers struggled to adjust to the frantic rush of operative procedures, staff members’ frenzied management of the situation increased their levels of anxiety. Perceived frenzied staff activity therefore increased mothers’ anxiety levels as they failed to understand what was happening around them. For some women, inadequate communication from staff was both frustrating and anxiety-provoking. In these instances, mothers reported feelings of uncertainty and insecurity. Moreover, they were left feeling excluded, dismissed and insignificant.

The rating of contact with staff in negative terms, the perception of inadequate intrapartum care, a lack of information during labour, a lack of participation in decision-making, and lack of support by staff has been found to be associated with increased anxious stress reactions to unplanned Caesarean section (Baston, Rijnders, Green, & Buitendijk, 2008; Creedy, Shocket, & Horsfall, 2000; Olde et al., 2006).

Lastly, mothers described an on-going concern for their babies’ health, as well as a period of separation from their babies immediately post-Caesarean. This was articulated as being extremely anxiety-provoking for women. Research explains that throughout births which require intervention procedures, mothers fear for their babies’ well-being (Clement, 2001; Creedy at al., 2000; Olde et al., 2006). Thus, when mothers expect to hold their babies and confirm that they are healthy, maternal anxiety stress responses increase with the duration of mother-infant separation (Feldman, Weller, Leckman, Kuint, & Eidelman, 2003).

These descriptions of feelings of vulnerability, helplessness, insecurity and fear all allude to the significance of a power variable. When preconceptions and expectations, dignity or esteem are challenged, the sense of loss of control can be overwhelmingly distressing and anxiety-provoking for women (Roux & van Rensburg, 2011). Soderquist et al. (2002) propose that women unable to integrate these traumatic experiences with prior expectations and core beliefs may be vulnerable to developing adverse post-partum emotional stress responses.

Post-Caesarean, mothers reported several stress responses that they perceived to have hindered their successful adaptation to motherhood. Physical limitations included diminished energy levels and a reduced capacity to perform several self-care and care-giving tasks. For some women, these symptoms persisted for a number of weeks after the birth and were identified as significant contributors to a stressful post-Caesarean experience. The occurrence of traumatic post-partum emotional responses further coloured the women’s already negative perceptions of childbirth. This was due to prolonged distress experienced during the unplanned
Caesarean section, and through the hindrance of the recovery process. In these instances, adjustment in the post-partum period and the transition to motherhood was complicated by mother’s own emotional adjustment difficulties.

Although not directly or conclusively correlated, women associated psychological stress and morbidity in the post-partum period with an adverse birthing experience (Roux & van Rensburg, 2011). After a traumatic birth experience, the new mother may experience numbness, emotional release, anger, loss, hyper-arousal, low self-esteem, and symptoms of depression (Ayers, 2007; Creedy et al., 2000; Olde et al., 2006). Women’s self-confidence and self-esteem were threatened as a sense of failure, self-blame and self-doubt left them feeling both inadequate about their own abilities and inferior to other women. Their disappointment and dissatisfaction in themselves and the birth process was significant in that, even when the outcome was a healthy baby, it tainted their overall perception and recall of the birth experience. Therefore, women’s perceptions of an emergency Caesarean can lower their self-esteem and leave them with a sense of failure, loss of control, disappointment, sadness, anger, and guilt (Fenwick, Gamble & Mawson, 2003; Gibbons & Thompson, 2001; Olde et al., 2006). Researchers warn that those women who are traumatised may experience difficulty in maintaining intimacy, and they may withdraw both emotionally and physically from others (Korja et al., 2009; Meijssen et al., 2010). Avoidance may result in failure to seek appropriate help or support, leading to isolation and inadequate cognitive processing, and in prolonging symptom duration (Ehlers & Clark, 2000). Thus, the occurrence of depressive illness as a stress responses following childbirth can be detrimental to the mother, her marital relationship and her child, and can have adverse long-term effects if left untreated (Robertson et al., 2004).

CONCLUSIONS AND LIMITATIONS

The experience of an emergency Caesarean section has been identified as a potentially traumatic and stressful experience, which has added to professional understanding of the adverse emotional consequences of surgical delivery on childbearing women (Creedy et al., 2000). Furthermore, some women may experience adverse emotional stress responses during the post-partum period. Even for those mothers who don’t develop acute stress or depressive symptoms, post-traumatic stress responses, grief and adjustment difficulties may all undermine a mother’s ability to successfully adapt to her role as a mother, meet the needs of her infant, and cope with post-partum challenges.

This exploration has important implications for preventive measures, therapeutic intervention and guidance. Professionals involved in pre-natal care should consider strategies for preventing post-Caesarean psychological distress through greater pre-natal preparation for Caesarean deliveries. Staff should be aware of the importance of positive encounters between themselves and women, as this will affect their levels
of satisfaction, comfort and support. These findings can contribute to midwifery and nursing literature by highlighting the difficulties associated with adjusting to an unplanned Caesarean section. Caregivers should be aware of the range of possible psychological responses to Caesarean section so that they may recognise psychological difficulties and distresses in the Caesarean-delivered mothers they care for, and so that they are able to provide the appropriate care and support. Moreover, the qualitative data contribute to the continuously developing body of knowledge about the diversity of mothers’ experiences of unplanned Caesarean sections.

Several methodological limitations may underestimate or misrepresent the impact of the present study. This study did not explore mothers’ psychiatric histories, nor did it investigate pre-natal mood and levels of stress. A woman’s pre-natal emotional functioning could affect her vulnerability and predisposition to the development of post-natal traumatic stress responses. The small sample may limit the generalisability of results. The study did not discriminate between planned versus unplanned pregnancies. This distinction could have important implications for the levels of preparedness, anxiety, and adaptation experienced. Furthermore, this research did not control for the use of instruments (e.g. forceps) or other interventions (e.g. labour induction) that may obscure subjective experiences and post-traumatic stress responses. The women that participated in this study were all Caucasian and thus the findings could be limiting. Within the South African context, there are women from other racial groups as the participated group who experience unplanned Caesarean sections. These women live in communities that hold different cultural values and it is important that their perspectives be explored to investigate how different cultural backgrounds may influence women’s experiences of unplanned Caesarean sections. Lastly, it is also possible that the effect of childbirth may have changed over time. As time passes, positive affect for one’s role as a mother may favourably colour a woman’s feelings about her birthing experience (Waldenström, 2004).

BIOGRAPHICAL NOTES

Samantha van Reenen completed a B.SocSci. Psych. degree (*cum laude*) and a B.SocSci. Psych. Hons. degree (*cum laude*) at the University of Pretoria. Thereafter, she completed a M.Sc. (Clinical Psychology) degree (*cum laude*) and a Ph. D. (Psychology) degree at the North-West University. Samantha is a clinical psychologist currently working at an addiction and psychiatric treatment facility as well as having a private practice. She is the co-author of several publications.
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STRESS RESPONSES EXPERIENCED BY A GROUP OF MOTHERS


