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University of the Witwatersrand
Department of psychology

Research Thesis for MA Degree

Exploring maternal identity formation of first time mothers who gave birth through a non-elective Caesarean Section

This is a research project submitted in partial fulfillment of the requirements for the degree of Masters in Clinical Psychology in the department of Psychology, University of the Witwatersrand, Johannesburg, 8 December 2016.

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Abstract

The performance of Caesarean sections is increasing around the world. In recent years, South Africa has seen a substantial rise in the number of Caesarean section deliveries. Literature has focused on the incorporation of the maternal role into a women's identity post-partum in general. However, less emphasis has been placed on how an unplanned method of delivery such as a non-elective Caesarean section influences this process against a backdrop of societal and self-imposed expectations. The current study explored the process of maternal identity formation of first time mothers who delivered their babies through a non-elective Caesarean section. The sample consisted of six first time mothers who gave birth through a non-elective Caesarean section. This is a qualitative, Interpretative Phenomenological Analysis (IPA) research design that utilized semi-structured interviews. The data was analyzed with the use of thematic analysis. Findings indicated that there is a strong need for mothers to be seen as 'good enough' and this impacts their ability to process their own birthing experience. There seems to exist negative judgment by other mothers and society in general around delivering through a Caesarean section; however the nature of this stigma cannot be named due to its impact on maternal identity. Other important themes that emerged include flexibility and control, the importance of support, and the psychological role of labor as a means of preparation for processing the idea of giving birth through a non-elective Caesarean section.

Chapter One: Introduction

The rate of Caesarean sections has increased worldwide (Naidoo & Moodley, 2009). South Africa has reported higher rates of Caesarean deliveries than most first world countries including America and England (Naidoo & Moodley, 2009). A Caesarean section refers to the process whereby a baby is delivered by a surgical incision in the lower abdomen of the woman (Smith, Plaat & Fisk, 2008). The term Caesarean section will be used interchangeably with 'Caesar' throughout the paper. Caesarean section deliveries are categorized into two main classifications namely elective and non-elective (Minkoff & Chervenak, 2003). This study focused on non-elective Caesarean sections which are performed when there is an imminent medical risk to the mother, unborn baby or both (Minkoff & Chervenak, 2003).

This study aimed to investigate the process of maternal identity formation of first time mothers who gave birth through a non-elective Caesarean section. The research has been situated within a psychoanalytical theoretical framework. The current study has aimed to explore how women make sense of their transition into motherhood in light of existing psychoanalytic theory relating to maternal subjectivity. Existing literature, although useful as a starting point, is scarce when considering the psychological effects of unplanned modes of delivery such as a Caesarean section on women. There has been a particularly limited focus in the literature on the impact of unplanned modes of delivery on maternal identity formation and how this is linked to the broader expectations of society of the 'good enough' mother. This project was exploratory research which aimed to gain insight into the reconciliation between birth expectations and lived experience of first time mothers' birthing process and how this is internalized by these women. Maternal self-imposed expectations about the birthing process are products of societal expectations of maternal role attainment. The process of maternal identity formation in this context is important to explore as the way in which women internalize their maternal identity has a significant impact on their psychological well-being and in turn determines their capacity to care for and bond with their baby.

This paper will detail the rationale for the study in chapter two. In chapter three, the pertinent literature will be discussed pertaining to Caesarean section deliveries; the definition of motherhood; maternal subjectivity and identity formation; societal pressures on women implicated in maternal identity formation and the influence of the birthing process on maternal identity. Chapter four will outline the methodological approach including the research design; sample and sampling; instruments; procedure; data analysis; ethical considerations and self-reflexivity. The results and discussion will be presented in chapter five and will explore the following themes: emotion and psychological defenses; flexibility and control; health of the baby as priority; expectations on women: the 'good enough mother'; the importance of support; and the role of labor and preparation. Chapter six is the concluding chapter that focuses on the strengths and limitations of the study; recommendations for future research and the conclusion.

Chapter Two: Rationale

The rate of Caesarean sections has significantly increased in South Africa and around the world (Matshidze, Richter, Ellison, Levin & McIntyre, 1998). In South Africa this is particularly true in the private health care division (Naidoo & Moodley, 2009). In 2004 Caesarean sections represented 65 percent of births in private hospitals as opposed to 10 to 20 percent in public health facilities (Naidoo & Moodley, 2009). This figure was notably higher than that of America and England (Naidoo & Moodley, 2009). Brunton, Wiggins and Oakley (2011) argued that the organic associations of pregnancy and birth have shifted to fit into a medical and sterile paradigm where pregnancy is viewed and treated as an ailment and childbirth is considered to be a medical procedure. Childbirth is no longer considered a natural process but one that has been appropriated into the western medical system (Brunton et al., 2011). This is set against a backdrop where medical concerns take priority over psychological consequences (Brunton et al., 2011). However, Caesarean sections also highlight the benefits of medical intervention where necessary as it has the potential to be a lifesaving procedure (Akinola, Fabamwo, Tayo, Rabiu, Oshodi & Alokha, 2014). The available literature on the subject is extremely scarce particularly in the South African context which emphasizes the need to conduct research in the area.

The maternal role becomes an important aspect of identity for many women (Akujobi, 2011). Women enter pregnancy and childbirth with certain expectations (Brunton et al., 2011). These expectations are largely determined by cultural and societal demands (Akujobi, 2011). Giving birth via an unplanned, non-elective Caesarean section is surrounded by a certain stigma as different modes of birth exist in a hierarchy each saying something different about a woman's perceived ability as a mother (Guittier, Cedraschi, Jamei, Boulvain & Guillemin, 2014). Vaginal delivery without pain medication and medical intervention is at the top of the hierarchy while Caesarean section appears to be much lower (Guittier et al., 2014). It is interesting to explore how expectations set out by society influence a mother's birth satisfaction and confidence in her ability as a mother and woman if these perceived expectations are not met. Further, it would be beneficial to explore how this influences maternal identity. These aims can be

achieved by exploring how first time mothers are able to develop their maternal identity after giving birth through a non-elective Caesarean section juxtaposed to their own expectations of the birth process and perceived societal expectations. The way in which a woman makes sense of her birth experience will underpin her ability to accept her role as a new mother (Nystedt, Hogberg & Landman, 2008). Research is still wanting on how an unplanned mode of birth such as a non-elective Caesarean section links to maternal identity formation and its psychological implications (Guittier et al., 2014). The research in this is area is scarce particularly in the South African context.

It can be argued that the birthing process is intricate and multifaceted (Guittier et al., 2014). One needs to consider many factors that affect a woman's appraisal of these experiences (Guittier et al., 2014). Research suggested that the birth experience itself helps to facilitate the transition into motherhood as it is a process that lends itself to profound physiological and psychological change (Nystedt et al., 2008). Much research has been conducted on different aspects that contribute to a negative or positive birth experience (Guittier et al., 2014). However research is lacking on the implications of unexpected modes of birthing on maternal identity formation (Guittier et al., 2014). This further emphasizes the gap in the literature on the psychological implication for first time mothers who deliver through an unplanned mode of delivery such as a non-elective Caesarean section.

Literature has suggested that women who deliver babies through a non-elective Caesarean section find it more difficult to initiate the shift in identity from non-mother to mother (Nystedt et al., 2008). This therefore delays the process whereby a woman can effectively partake in maternal activities and the caring of her newborn baby (Nystedt et al., 2008). The above statements have been made on the premise that an unplanned Caesarean section is linked to a negative birth experience as it may have associations to trauma (Nystedt et al., 2008). There was evidence to suggest that a non-elective Caesarean section has been associated with Post Traumatic Stress Disorder-like symptoms such as flashbacks (Rowlands & Redshaw, 2012). Therefore, insight is needed on how the above factors culminate in the formation of maternal identity in light of an

unexpected birthing process such as a non-elective Caesarean section. This information will be useful in various domains such as the mental health domain, specifically for gynecologists, mid-wives and psychologists.

Research Aims

Given the above, the primary aim of the current study was to investigate the process of maternal identity formation of first time mothers who gave birth through a non-elective Caesarean section. The research set out to explore how mothers internalize their actual birth experience in light of their birth expectations and how these expectations may be linked to societal standards of 'good enough' mothering.

Chapter Three: Literature Review

A discussion on existing literature on topics related to maternal identity and modes of birthing has been compiled in order to highlight the gaps in literature that exist in this domain, as well as provide a background against which this current study was conducted. Areas that have been discussed include the definitions of Caesarean section deliveries and motherhood; maternal subjectivity and identity formation; as well as the influence of the birthing process on maternal identity.

Caesarean section deliveries

Caesarean section deliveries refer to the process whereby babies are delivered through an incision in the abdomen of the mother (Smith et al., 2008). Caesarean births have not only become a conventional form of delivery but have significantly increased in recent years (Naidoo & Moodley, 2009). Caesarean section deliveries are grouped into two categories namely elective and non-elective (Minkoff & Chervenak, 2003). Within the non-elective category exist two sub-categories referred to as 'urgent' and 'emergency' (Naidoo & Moodley, 2009). Elective Caesarean sections occur when the mother and health care practitioner agree before the birth process is initiated that a Caesarean section will be the optimum form of delivery for various reasons (Minkoff & Chervenak, 2003). A date is pre-arranged for the procedure. This type of Caesarean section usually occurs after a previous Caesarean section; planned or unplanned.

Non-elective Caesarean sections are unplanned. This suggests that the mother had alternative expectations coming into the birth process. Urgent non-elective Caesarean sections occur when either the mother and/or unborn baby are found to be medically at risk (Penna & Arulkumaran, 2003). However, the threat is not immediate (Naidoo & Moodley, 2009). On the other hand, an emergency Caesarean section occurs when the mother's and/or unborn child's life is in immediate danger (Penna & Arulkumaran, 2003). It is evident in the limited availability of resources that the literature on this topic is sparse, further reinforcing the need to conduct research in this area.

The definition of motherhood

The concept of motherhood can be defined as an instinctive psychological mindset that results in specific behaviors and attitudes catalyzed by pregnancy and birth (Akujobi, 2011). This is not limited to a psychological shift but also includes a profound change in overall identity as a woman incorporates new aspects of herself as a mother into her existing framework of self-reference (Akujobi, 2011). She is inextricably linked to another individual and therefore her self-concept needs to adapt in order to account for her new role as a mother (Akujobi, 2011). The experience of this process is greatly influenced by social and cultural factors. The maternal role itself is largely a product of context (Akujobi, 2011). Different contexts have different definitions of the role of the mother. This is largely determined by culture and society. The building blocks of maternal identity are set out in early childhood (Perun, 2013). Concepts of motherhood and expectations of the maternal role are acquired through interactions with maternal figures in childhood. Definitions of this role have evolved and still continue to evolve (Akujobi, 2011). Many religious groups such as Christian, Judaic, Hindu and Islam place great significance on the maternal role (Akujobi, 2011). So much so that the ability to bear and raise children is enmeshed with female identity and represents femininity for certain cultures (Akujobi, 2011). Both the identity of the mother and the woman are closely linked (Perun, 2013).

At the outset, women are expected to become mothers in many societies and religious factions. For example, in some African cultures a woman who is unable to fall pregnant is not considered to be a whole and complete woman but rather an individual that requires pity (Akujobi, 2011). The maternal role holds high regard in society (Raphael-Leff, 2010). The actual act of giving birth itself is considered an appropriate rite of passage into womanhood (Akujobi, 2011).

Motherhood is not necessarily limited to a biological definition and can include mothers that have not given birth; however, the focus of the current study is confined to this

biological definition given the focus is on birth delivery and its impact on maternal identity formation. One has to explore what is the definition of giving birth, does it involve active or passive involvement and if so, what implications does this have on a woman's status as a woman and mother.

Raphael-Leff (2010) argued that psychoanalysis and psychoanalytic theory has been criticized for the conflation of the female and maternal identities and does not often make room for women who choose not to be become mothers. This highlights the pressure placed on women to attain the maternal role and once this is achieved through birth, her maternal identity is further influenced by societal expectations of the 'good-enough' mother (Raphael-Leff, 2010). Thus the act of giving birth is closely intertwined with a woman's identity as a mother. Consequently, it is important to consider how not being able to give birth naturally and having to have a non-elective Caesarean section links to maternal identity formation.

Maternal subjectivity and identity formation

Donald Winnicott (1960) postulated that maternal identity formation begins in pregnancy. When a woman is pregnant she undergoes biological and psychological changes. The biological changes that occur within her body cause her to shift her focus to herself (Winnicott, 1960). The process of pregnancy allows the expecting mother to progressively develop a sense of identification with her child (Winnicott, 1956). This identification reaches a peak just before the baby is born and decreases within the first few months after delivery (Winnicott, 1956).

Winnicott (1956) spoke about a fundamental maternal role of the mother that allows her to meet the needs of her baby through a process of biological conditioning. She is responsible for providing an optimal environment for the development of the child and allows the child to feel secure. Her ability to provide a conducive environment occurs through her sensitivity to her baby's needs and her devotion in meeting these needs. This devotion occurs at such a level whereby the mother is wholly focused on the needs of her baby to the point whereby she puts her own needs aside (Winnicott, 1956). The process

of holding is of prime importance and is based on empathy (Winnicott, 1960). If this does not occur the baby does not develop a consistent continuity of being as he or she begins to try and negotiate a sense of presence in life (Winnicott, 1960). This stage of primary maternal preoccupation is usually psychologically repressed by the mother once she has passed through it and is relinquished through a gradual process of learning to adapt to the growing infant's needs and negotiating the change from being merged with the baby to increasing separateness (Winnicott, 1960). Repression is a psychological defense mechanism whereby one unconsciously wills to forget material that might underlie psychological injury (Lemma, 2003).

Psychological defenses serve an adaptive function in psychological maturation (Cramer, 1998). Defenses largely originate on the level of the unconscious (Cramer, 1998). In psychoanalytical understanding, the unconscious refers to certain thoughts and drives that exist beyond awareness due to their nature but have a profound impact on one's behavior (Lemma, 2003). Psychological defenses can become characterological in nature or be situational. In other words, characterological defenses tend to be rigid and embedded within personality and interpersonal relating. Situational defenses develop as a reaction to a specific event or context and are not deeply embedded within personality (Lemma, 2003). Certain defenses are deemed appropriate and adaptive while others can be considered as more primitive and less functional (Lemma, 2003).

In light of the above, traditional psychoanalytic theory has been criticized for overlooking the idea of maternal subjectivity (Raphael-Leff, 2010). The idealization of the maternal function can lead to unavoidable failure by a woman (Raphael-Leff, 2010). Later psychoanalytic theorists such as Benjamin (1998) refuted the idea that the mother solely acts as a reflection to the needs of her child. Rather the mother needs to represent a degree of separateness from her baby. The constant need to be attuned to one's infant can be overwhelming (Raphael-Leff, 2010). The way in which a woman responds to her child illustrates a recognition for difference which exists within the individual and can be processed by the baby as her existing with a separate subjectivity. This process is recognized by Winnicott (1953) whereby the child is able to distinguish between

similarity and difference when they are older. However Benjamin (1998) tended to emphasize the role of maternal subjectivity in its importance for not only the infant but also for the mother herself. This idea is echoed by Stone (2012) who highlighted the challenges women face in their recognition of themselves as a separate entity from their children with their own internal world and needs.

The difficulty for mothers in recognizing their own subjectivity must also be considered in light of maternal ambivalence which is considered to be part of maternal identity formation (Lewis, 2002). Women feel the need to suppress these ambivalent feelings in order to feel as though they are adequately responding to the needs of their child. The acknowledgment of ambivalent feelings often leads to guilt and feelings of inadequacy in the maternal role (Lewis, 2002). Given the above debate, it is important to consider whether maternal subjectivity has a place in psychoanalytic thinking and in so doing, what is the process of maternal identity formation within a psychoanalytic paradigm. The current study took an overall psychoanalytical framework and aimed to gain access to the maternal subjective experience in light of participants' birthing experience and process of negotiating their maternal identity.

Societal pressures on women implicated in maternal identity formation

Maternal identity formation is a complex process. A character shift begins to take place early on in the gestational period (Darvill, Skirton & Farrand, 2010). Maternal identity is made up of many parts specifically affective, cognitive, behavioral and axiological components (Perun, 2013). The affective component is concerned with a woman's perception of herself as a mother. These attitudes and perceptions are shaped by a metanarrative and exist beyond the attachment of the individual to her child. Feelings of competence as a maternal figure are therefore directly related to social and cultural factors (Perun, 2013).

Furthermore, maternal identity refers to acquired conscious and unconscious knowledge about the maternal role (Perun, 2013). In other words, the purpose of a mother and her beliefs concerning childrearing fall within the cognitive component of maternal identity

(Perun, 2013). Knowledge of the maternal role is also a product of a broader belief system outlined by society and culture. Therefore, much of how a mother defines herself in that role is in reference to how society perceives the ideal mother which places a large amount of pressure on women to meet these expectations.

Pre-existing value systems around motherhood in general are known as the axiological component (Perun, 2013). This component is also directly related to societal and cultural expectations and systems of knowledge. Therefore, one's exposure to forms of mothering throughout one's life has an important role in shaping one's attitude around the maternal role (Perun, 2013). This links to the experience of one's own mother as well as how mothers are generally viewed by the society that one has grown up in and in turn, shapes one's perceptions about motherhood.

Therefore, much of how a woman perceives herself in the maternal role, her attitudes, beliefs and knowledge is directly influenced by society and culture. Other factors that contribute to the formation of maternal identity include socio-economic status, marital situation and career (McMahon, 1995). Maternal identity is not a fixed construct and varies among individuals (Perun, 2013), as well as over time. This variation can be linked to perceived attitudes of others, as well as of the mother, towards different birthing methods such as a Caesarean section and its effects on maternal identity. The existing research on the socio-cultural facets of pregnancy and birthing is extremely scarce particularly in the South African context. This further emphasizes the need for continued research in this area.

The influence of the birthing process on maternal identity

Perun (2013) suggested that the ability to transition into the maternal role is closely linked to the experience of the early post-partum stages and is characterized by mother and child interaction. Positive early experiences are necessary to ensure consolidation of a positive maternal identity. Therefore, the manner in which a new mother is able to internalize her birthing experience and her first interactions with her baby has a significant impact on the consolidation of maternal identity. A number of elements

contribute to the overall birthing experience namely levels of support, a sense of control, amount of pain experienced and the need for medical intervention (Ford, Ayers & Wright, 2009).

Nystedt et al. (2008) discussed a number of elements that are related to internalized negative birth experiences. Such factors can include a loss of control, diminished active participation in the decision making process, medical interventions and an unplanned mode of delivery. Control is an important element in the birthing process and is experienced contrarily in the various modes of delivery (Rijnders, Baston, Prins Schonbeck, Pal, Green & Buitendijk, 2008). However, an unplanned Caesarean section and the resulting lack of perceived control for the mother can lead to a negative birth experience (Guittier et al., 2014). It can be argued that the method by which a woman delivers her baby is one of the most reliable indications for whether or not her birth will be perceived as a positive or negative experience (Guittier et al., 2014). The discussion of mode of delivery is a contested one. Traditionally, a natural delivery is considered to yield a positive internalized experience (Hildingsson, Johansson, Karlstrom & Fenwick, 2013). This in turn directly affects a woman's maternal identity formation, societal expectations and the role of herself as a mother. This is evident as there are strong general perceptions amongst women around modes of delivery which in turn influences how women internalize their birthing experience and hence begin to form their maternal identity. The above research tends to suggest that natural childbirth is considered superior to Caesarean deliveries, possibly an attitude many are influenced by in society which would impact on a woman's maternal identity formation.

Interestingly, some research such as Guittier et al. (2014) indicated that elective Caesarean sections also yield positive birth experiences, in so far as an elective Caesarean delivery may reduce anxiety around the birthing process as the timing of the birth is more easily controlled by the woman and her doctor and there is less fear about the unknown of the labor process. A positive appraisal of the birthing experience allows the mother to feel a sense of accomplishment and self-affirmation (Guittier et al., 2014). These are

important feelings in the establishment of maternal identity as they encourage a smoother transition into motherhood (Hildingsson et al., 2013)

On the other hand, a negative birthing experience has psychological implications for a new mother's mental health (Nystedt et al., 2008). This is particularly noticeable in cases of a long, unsuccessful natural labor where a woman expects to deliver vaginally followed by a medically assisted delivery (Nystedt et al., 2008). Evidence suggests that women who deliver via an unplanned Caesarean section display characteristics of compromised mental health as opposed to those women who give birth through elective Caesarean sections or vaginally (Rowlands & Redshaw, 2012). This suggests a form of trauma to the mother coupled with feelings of terror and lack of agency post-partum (Nystedt et al., 2008). This may negatively impact a woman's ability to bond with her child in the period following birth. A mother's ability to adequately connect with her child is compromised on a psychological level due to the trauma, as well as on a physical level due to the nature of the procedure that is surgical and unplanned (Nystedt et al., 2008). The above exists in conjunction with the difficulties that often accompany new mothers after birth such as exhaustion and sometimes even a sense of loss (Nystedt et al., 2008). It can be deduced that the process of maternal identity formation is disrupted in the instance of a negative birth experience.

Guittier et al. (2014) aimed to explore how the mode of delivery impacts on the mother's birth experience. Women were asked to express their expectations of the birthing process. There is an intricate and dynamic interplay when exploring maternal expectations of the birthing process as these expectations are continually revised through new and developing experiences unique to the individual (Ayers & Pickering, 2005). Results indicated that vaginal delivery was perceived by the women in Guittier et al.'s (2014) study as the optimum method of delivery, as well as the method that holds the most merit in terms of status as a mother and a woman. The experience of pain acted as an important means of self-validation in one's ability as a mother. Delivering vaginally was linked to feelings of accomplishment, self-worth and pride. The same feelings were not expressed in mothers who delivered through a non-elective Caesarean section (Guittier et al., 2014).

In fact, many of the participants in that study felt that their maternal ability had been undermined, accompanied by feelings of self-degradation in light of the fact that they were unable to deliver vaginally; something which they felt that they should have been able to accomplish (Guittier et al., 2014). These feelings were amplified as their own expectations of their birthing process had not been fulfilled which led to a sense of failure (Lobel & DeLuca, 2007). Such women are at a higher risk for developing post-partum-depression (Lobel & DeLuca, 2007). Similar results were echoed by Rowlands and Redshaw (2012) whereby women who delivered via a non-elective Caesarean section were found to be at a greater risk for developing depression as they displayed feelings of low self-worth and negative attitudes towards their birth experience. These expectations have formed as a result of internalizing aspects of their own childhood and engaging with their potential role as mothers (Ayers & Pickering, 2005). The experience of one's own parents and engagement in one's future aspirations as a mother themselves has a significant impact on maternal expectations and in turn forms the basis of birthing and maternal role expectations. Raphael-Leff (2010) argued that one cannot ignore how internal representations of one's own mother shape maternal identity.

From the above review, it is evident that more research needs to be conducted on the effects of a non-elective Caesarean section on maternal identity formation. The existing literature, although interesting and beneficial, is scarce and has limited focus on the psychological effects of this unplanned mode of delivery. The above needs to be explored against the backdrop of societal expectations of the role of the mother and how this is linked to self-imposed expectations.

The review of the existing literature on topics related to maternal identity and modes of birthing raised many questions and therefore the following research questions were decided upon for the focus of the current study.

Research Questions

1. What is the process of maternal identity formation of first time mothers who gave birth through a non-elective Caesarean section?
2. How are birth expectations and lived birthing experience reconciled and internalized by first time mothers who gave birth through a non-elective Caesarean section?
3. How is maternal identity formation linked to societal expectations of the role of the mother in first time mothers who gave birth through a non-elective Caesarean section?

Chapter Four: Methods

Research Design

This study is in the form of a qualitative research design. Qualitative research aims to provide rich and in-depth data in order to gain insight and understanding into the topic being explored (Terre Blanche & Durrheim, 1999). More specifically, an Interpretative Phenomenological Analysis (IPA) was used as framework in which the data was approached. Larkin, Watts and Clifton (2006) view IPA as a helpful paradigm through which to attempt to make sense of data rather than it being a specific method. In other words, through the use of IPA, the researcher aimed to explore and understand the subjective nature of the participants' lived experiences and particularly, the way in which participants make meaning of these occurences (Smith, 2004). The researcher then attempted to try comprehend the ideographic nature of the particular lived experience and then locate this understanding within a broader socio-cultural context (Larkin et al., 2006). Thus the current study aimed to explore the nature of an individual's experience of birthing and maternal identity formation specific to the particular person and how this relates to societal expectations on modes of birthing. The above approach lends itself to the use of one-on-one semi-structured interviews and the results were analyzed through thematic analysis. Thematic analysis is the process whereby the data was grouped into various themes to aid analysis and interpretation (Braun & Clarke, 2006).

Sample and Sampling

The sample consisted of six first time mothers who delivered their babies through a non-elective Caesarean section in a private South African hospital. More specifically, this non-elective Caesarean delivery was an emergency. This size sample is sufficient in such qualitative research as the aim of the research is to gather in-depth and rich data as opposed to information relating to incidence and prevalence (Ritchie, Lewis & Elam, 2003). Further, this sample is appropriate as significantly more Caesarean sections are performed in the private health care sector as opposed to the public health care sector (Matshidze et al., 1998). The participants' children were between the ages of ten months

and three years of age at the time of the interview. This age range allowed for some time for mothers to process different aspects of their maternal identity since the birth of their baby. Winnicott (1956) argued that maternal identity formation is a process and this period post-partum mentioned above allows some time for the mother to move beyond the space of primary maternal preoccupation into the role of the 'good-enough mother'. All participants had one child and two were pregnant with their second child at the time of the interview. All six participants were English speaking and thus all interviews were conducted in English. Participant ages ranged from 25 to 41 years old. All six participants were white middle class females and at the time, all participants were in a stable, romantic relationship with the father of their child. This relationship status was a criterion for the current study in order to attempt to eliminate extraneous variables that would further influence the process of negotiating maternal identity. These variables may have included teenage pregnancy and being a single mother. Mothers who developed post-partum depression were not included in the study for the same reasons.

The method of non-probability, convenience sampling was used to recruit potential participants for the study. There was not an equal chance that all members of the population would be included in the sample but rather, a sample was selected by the researcher based on certain characteristics within an accessible population (Kothari, 2004). Therefore, the sample was not randomly selected but selected by the researcher based on criteria that needed to be fulfilled by participants (Terre Blanche & Durrheim, 1999). Participants were approached by the researcher using a group on a social Media platform, specifically, Facebook. The Facebook group is aimed towards mothers in Johannesburg. The researcher's post in this social media group included the topic of the study and asked potential participants to private message the researcher should they wish to receive more information about the study. The post was as follows:

> "Hi Ladies. I am conducting research for the purpose of obtaining my Masters degree in Clinical Psychology. I am exploring maternal identity in first time moms who delivered through a non-elective Caesarean section. If you delivered your first baby through a non-elective Caesarean at least 6 months ago and you

are interested in participating, please private message me for more info. Thank you."

Women who responded to the advert were asked to provide the researcher with their email address. The researcher then emailed potential participants the participation information sheet (Appendix Two) outlining the details of the study. Those that were interested in participating were asked to email the researcher back with their contact details in order to allow the researcher to call them and set up an appropriate time and venue for the interview.

Instruments

As mentioned above, a one-on-one semi-structured interview was used to explore the participants' birth experience of having undergone a non-elective Caesarean section and how this experience has influenced the development of their maternal identity. This technique made use of open-ended questions which allowed the participants the opportunity to express their views without too much guidance by the researcher (Terre Blanche & Durrheim, 1999). The interview began with demographic information and then participants were asked about their birth experience and their feelings around the experience. The researcher made use of an interview schedule compiled by herself (see Appendix One) after reading the existing literature and research on this topic. Participants were also asked questions about their birth expectations prior to the event and how they reconciled these expectations with the actual process and outcome of their birth experience. The researcher attempted to engage with these narratives and the participants' feelings and attitudes towards their birth experience. Such questions included

"Please tell me about your first birthing experience?" and

"How did you feel immediately after the birth about your birthing experience?"

Perceptions around societal expectations of giving birth and maternal competency were also explored. These questions were as follows

"How do you understand society's and your culture's perceptions on motherhood and mode of birthing?" and

"What do you think, if any, are society's expectations on different birthing options?"

Questions around the meaning of the birth process and the perception of one's own capability as a new mother were explored such as

"Please describe what type of mother you are?" and

"What do you feel is important to you in this role?"

Interviews allowed the researcher to engage with the participants as well as yield rich data. It also gave the researcher the opportunity to clarify certain points if the participant was unsure what is being asked of them. Please see Appendix One for the full interview schedule.

Procedure

Once ethical clearance was obtained from the University of the Witwatersrand Psychology Department's internal ethics committee, first time mothers, who delivered babies through a non-elective Caesarean section, were approached by the researcher and were invited to participate in the research study through a group on social media. Mothers who were interested in participating in the research were asked to private message the researcher and provide their email address. The researcher then emailed potential participants the participant information sheet (see Appendix Two). Those who were interested in participating in the research were asked to reply with their cellphone numbers in order to allow the researcher to contact them to arrange a time and place for the interview. The researcher arranged to meet participants at their houses at a suitable time for them. When the researcher arranged to conduct the interview, the details of the research were explained to the participants. The researcher explained the topic of the study, its purpose and what it entailed. It was explained that the interview would take between 45 minutes to one hour. The researcher also discussed that a consent form needs to be signed before the interview could take place. Other ethical issues such as confidentiality, recording of interviews and the sharing of data with her supervisor were discussed. These ethical concerns were discussed again at the start of the interview. The interviews were recorded by an audiotape and transcribed verbatim for analysis. Participants were asked for permission for the storing of anonymized transcripts for the possibility of future research.

The researcher explained that if the participants had any concerns or questions during the research process, they should feel free to contact the researcher. If the researcher was unable to adequately address their concerns, she would ask the advice of her supervisor. However, none of the participants contacted the researcher with concerns or questions about the research. At the end of the interviews participants were thanked for their participation.

The interviews were then transcribed verbatim and analysed.

Data Analysis

The researcher used thematic analysis to explore dominant themes and attitudes across the data. Specifically, thematic analysis as per Braun and Clarke's steps (2006) was used to analyze the data. This included the grouping of the data into general themes. The above yielded in-depth and rich data. This technique allowed a large volume of data to be categorized into common themes and was therefore suited to summarizing the data into various trends or patterns (Terre Blanche & Durrheim, 1999). Thematic analysis does not require specialized equipment but relies on the discretion of the researcher (Terre Blanche & Durrheim, 1999). It was imperative that the data was coded in a consistent manner according to a set of pre-existing rules established by the researcher. Thematic analysis categorizes the manifest content of speech or text in order to explore latent content. It is a form of coding speech in order to explore certain meanings and attitudes of the participants (Terre Blanche & Durrheim, 1999). Braun and Clarke (2006) outline six steps in the thematic analysis process. These steps include the need for the researcher to familiarize him or herself with the data; transcribe the data verbatim; start identifying certain codes which leads to the next step that involves identifying dominant themes. The researcher is then required to reassess these themes in order to ensure the data falls into a consistent pattern (Braun & Clarke, 2006). Step five involves further modification and description of themes while step six is concerned with the reporting of results (Braun & Clarke, 2006).

Ethical Considerations

A number of ethical standards have been established within the field of psychology in order to ensure the practice of ethical research. These standards aim to guarantee the safety and integrity of participants as well as the researcher and in turn, establish the legitimacy of the research itself. These will be discussed accordingly.

No intentional harm

No intentional harm was inflicted on the participants. In the case that participants may have felt unsettled with the research situation, the contact details of the researcher as well as her supervisor were provided on the participant information sheet. (Please see Appendix Two). However, none of the participants contacted the researcher or supervisor in such circumstances. Due to the potentially sensitive nature of the topic, participants could have been referred for free counseling if this study elicited any emotional effects in them. The information for a free counseling service was provided to participants before the interview began so that they were aware of it from the start. If the participant had preferred to seek private psychotherapy, the researcher would have provided them with the names and contact details of psychotherapists upon request (please see the Participant Information sheet: Appendix Two). However, none of the participants requested referrals for private psychotherapy.

Participant Consent

A participant information sheet was provided to each participant explaining the concept of consent, explaining the purpose of the study and supplying relevant contact information should the participants have any concerns or questions during the process. However none of the participants contacted the researcher or supervisor with any concerns or questions. This sheet also allowed the participant the opportunity to consent for the interviews to be audio-recorded as well as to the possibility that the anonymized transcripts may be used for future research.

Voluntary nature of the study

Participants were not forced to take part in the study and were free to withdraw from the study at any time during the process, without any negative consequences. None of the participants withdrew from the study.

Ensuring safety and privacy of information shared in the interview

Participants were identifiable to the researcher due to the nature of face-to-face interviews. Their identity in the research report was protected by the use of pseudonyms and limited personal details were asked. Anonymity was protected in the final write-up of the study. Furthermore, confidentiality was also guaranteed between the researcher, her supervisor and the participants. Pseudonyms given to each participant assisted in maintaining confidentiality and final anonymity. The information yielded has remained confidential as only the researcher and the supervisor have had access to this information. Participants were notified that the interviews were to be recorded but only the researcher and the supervisor have access to these recordings. This data has been stored on a password-protected laptop and the audio-recordings will be deleted after the completion of the degree.

Researcher's responsibility to the community

The findings have been recorded in the current research report of which publication may result. Results are made available to the participants on request. The participants were provided with the researcher's and supervisor's telephone numbers and email addresses and were invited to contact the researcher towards the end of the same year of the interview should they wish to see the final research report. The data collected has been stored on a password-protected laptop therefore restricting outside access to the data.

Self-Reflexivity

Self- reflexivity is the process whereby the researcher needs to be aware of their own position within the research in order to ensure the transparency of the findings (White, Woodfield & Ritchie, 2003). Due to the nature of self-reflexivity I have chosen to write this section in the first person.

I am a woman as well as a mother who delivered my child via a non-elective Caesarean section. Thus I had to be aware of my own thoughts and feelings throughout the research process and specifically when these were the same and different from the participants. This was important to hold in mind through the process. It was vital the I remained open to experiences and feelings that were different from my own. I also had to keep in mind how I came across to the participants and how they would feel about talking to another mother and whether this would affect the interviews and the information they shared. This was evident in certain power dynamics between myself and some of the participants, specifically in the transference and countertransference during the interview process. Transference refers to aspects of the researcher and participant relationship shaped by the participants' perception of the researcher and their projections (Lemma, 2003). While countertransference represents the researcher's reaction to the participants (Lemma, 2003). Both processes are involved within the interview process as rapport is built. I believe certain participants became psychologically defensive and felt like I was judging their ability as a mother, especially as I work and think within a psychological framework. I needed to admit my own capacity to be judgmental, both in a personal and professional role. I used my personal, on-going psychodynamically-orientated psychotherapy as an opportunity to think about and process my position within the research. This is important to note, as I am the subjective instrument through which the interpretation happens (Pope, Ziebland & Mays, 2000). Interpreting and analyzing the data through a psychodynamic lens also has implications in the way in which the data is interpreted and I am cognizant that a different lens or paradigm would have different meaning for another researcher. However, the perspective is useful for me as someone who practices psychotherapy from a psychodynamic perspective.

Chapter Five: Results and Discussion

This chapter aims to deliberate the themes extracted from the interviews with the participants using thematic analysis within an IPA framework. Existing research and literature has also been included in order to broaden the discussion of the various themes and deepen the understanding of the participants' birthing experiences. The six themes evident in the data that will be discussed below include emotion and psychological defenses; flexibility and control; health of the baby as priority; expectations on women: the 'good enough' mother; the importance of support; and the role of labor and preparation. However, first an outline of the sample will be given to help enrich the discussion to follow.

Characteristics of sample

The sample consisted of six first time mothers whose ages ranged from 25 years to 41 years. The ages of their babies ranged from 10 months to 3 years old. All the mothers in the sample had experienced an induction for various reasons and then underwent an emergency Caesarean section.

Participant one (Sharon) is a 25-year-old, white female who has a son of 14 months and was pregnant with her second child at the time of the interview. She delivered her son through a Caesarean section as her baby was in distress due to an increase in the induction medication. Participant two (Sally) is a mother to a 3-year-old girl. She is a white female and is 32 years of age. Sally delivered her daughter via a Caesarean section as she had pre-eclampsia and her labor was not progressing despite the use of induction medication. Participant three (Nadine) is a 29-year-old white female with a daughter of 15 months. Nadine also had an induction and her baby's heart rate dropped and therefore she delivered her baby via a Caesarean section. Participant four (Lisa) was pregnant with her second child at the time of the interview and has a 10-month-old boy. She is a white female and delivered her baby boy via Caesarean section as his heart rate dropped drastically. Lisa was also given medication to progress her labor. Participant five (Natalie) is a 41-year-old white female who has one son that is 20-months old. She was

induced and tried to deliver naturally, however during the pushing process, her baby became stuck and she then needed to have an emergency Caesar. Participant six (Tanya) was also induced and had a Caesarean section as her labor was not progressing. She is a 26-year-old white female and has a 15-month-old baby girl.

Overall, Sharon, Nadine, Natalie and Tanya reported being content with their birth experience, while Lisa remained ambivalent, and Sally was disappointed with the experience of a Caesarean section. Sharon, Nadine and Tanya would like to consider a Vaginal Birth after Caesarean (VBAC) for their next delivery in consultation with their doctors, while Lisa is very committed to having a VBAC. Nadine would have an elective Caesar and Sally does not want to have more biological children. The prominent themes across their stories will now be discussed.

Theme One: Emotion and psychological defenses

Throughout many of the interviews there was a sense of disconnection from emotion within the participants' stories. It appeared as though many participants struggled to name their feelings. Participants were more comfortable describing their physical states of being, such as exhaustion or pain, rather than their emotional experiences at the time of the birth. Feelings during the birthing experience were difficult to relay to the interviewer. Some participants, including Nadine and Sally, reported feeling disconnected from the birthing experience due to the exhaustion of the birthing process. It appears as though other participants such as Lisa diverted from emotion as an attempt to mask some kind of underlying emotional pain. Further, some mothers such as Sharon and Lisa, described the lack of opportunity to process their feelings around the birth.

With some participants the inability to process their emotions around their birth experience was related to the use of healthy psychological defenses by focusing on moving forward into their transition into motherhood. This was evident in their focus on adjusting to their role as a mother once they had given birth. Other participants' reluctance to process their emotions around their birthing experience was linked to a more rigid defensive structure particularly around not giving themselves the time to feel

and to process as a means to avoid psychological pain and vulnerability. It is postulated that this avoidance of feeling and emotion was aimed at protecting the maternal identity and the need to be seen as a 'good' mother (Lewis, 2002). As Sally expressed that guilt had tarnished some of the joy of becoming a mother and made her transition into motherhood more difficult. She stated *"and the guilt. You know like coming to terms with what I had gone through and like getting over the sense like I didn't fail. It wasn't like a failure. I had a healthy baby and all that and trying to switch my attitude about that."*

Another emotion that emerged within the participants' narratives was fear, which is also linked to the need to be a 'good' mother. This fear was also related to the idea of the unknown, fear of pain and implications of birth on the post-birth body. Tanya expressed "*when I was pregnant I had these huge anxieties… am I going to love the baby? Am I going to be a good mom?... Listen I did have fears also about if there was going to be pain, would I cope and all those kinds of things."*

Many participants including Sally, Nadine, Lisa and Natalie struggled to engage with questions that required self-reflexivity. This was evident when the participants were asked to describe themselves as a mother. Stone (2012) explained that mothers find it challenging to view themselves as subjects and in so doing find it hard to exercise tasks that require subjectivity. This develops out of the way mothers are regarded by other individuals as they are seen to be primarily responding to the needs of their child (Stone, 2012). It was apparent that participants in the current study found it easier to name feelings of other people as they relayed birthing experiences of friends and family. This will be discussed further under the theme entitled "sharing of stories". The inability for mothers to engage with their own subjectivity affects their ability in the creation of their own experiential meaning (Stone, 2012) Those that struggled to process their internal emotional experience seemed to display evidence of unprocessed anger towards their doctors. This was illustrated through blame and by painting medical staff in a malevolent manner. This is another psychological defense referred to as sublimation. Sublimation is the process whereby threatening thoughts or feelings are redirected to a socially acceptable target (Lemma, 2003). In other words, doctors may become the target of this

unprocessed anger. The threatening thought or feeling is therefore rendered less powerful through this process. Lisa expressed *"I mean I feel… the fact that my doula feels* [that the doctor] *rushed things… and what kind of irritates me now is that my gynae was on call that night. So she was at the hospital anyway so if she was going to be around, she was… she… I mean in my view… maybe she had other reasons for having to augment me quickly… we never really chatted about it. They* [doctors] *never like answering questions."* Feelings of anger in becoming a mother are not uncommon in first time mothers (Parfitt & Ayers, 2014), however women who have an unanticipated birthing experience may feel greater levels of anger than those women who managed to meet their birthing expectations Women indeed experience a whole range of feelings which may be difficult to express in their role as a mother (Benjamin, 1988).

Doctors are labeled as pro-Caesar or pro-natural within the participants' narratives and there is a skepticism around their intentions and the medical system in general. Lisa stated that "*doctors like to induce you and get everything going."* And *"I feel like doctors have made it easy to go the Caesar route."* Most participants expressed skepticism around the high rate of Caesarean sections in South Africa, particularly with regards to whether they were due to 'real' emergencies or performed at the will of doctors. Sharon relayed in relation to her own birth that *"maybe it wasn't such an emergency. Maybe it was just the doctor being overly cautious or really wanting to go to bed because it was three o'clock in the morning and he had been back at the hospital four times that night."* The foregrounding of doctors is also linked to a need to absolve oneself of responsibility which may negatively impact maternal identity, specifically that of being the 'good enough' mother. Research conducted by Tully and Ball (2013) indicated that most Caesarean sections within their sample were performed as a result of a failure to progress labor and not due to the distress of the baby which gives weight to these skeptical views by the participants.

1.1: Sharing of stories

A sub-theme of this first theme is that most participants shared birthing experiences of family members and friends and this served as a means of comparison for their own

experience. As mentioned above, many of the participants struggled to engage with their own emotions related to their birth experience and maternal identity formation. Many of the stories shared were linked to women who struggled with coming to terms with having a Caesar and as a result they felt like less of a woman, wife and mother. Nadine expressed *"I mean I do know somebody who she also labored for hours and in the end when she had to have a Caesar, she was devastated. Even though ultimately her baby was fine and she was fine… somebody in a similar situation pushed through and had a natural so she kind of felt that maybe she missed out."*

Experiences of trauma disrupt the individual's ability to coherently narrate their own experience thereby hindering their ability to process the experience (Tuval-Mashiach, Freedman, Bargai, Boker, Hadar & Shalev, 2004). Therefore, the sharing of others' stories served a particular function for some of the participants and this was related to the individual's difficulty in expressing their own internal world. It is less threatening and easier to make sense of the emotional experience of the other. These stories were used as a tool to connect to, and illustrate, more difficult emotions such as guilt and disappointment related to their maternal role and identity.

Theme Two: Flexibility and control

There was a general feeling amongst the participants that going into birth with a rigid plan as to how the birth would take place is not constructive. In fact such a plan can be destructive as the birthing process is out of one's control. Lobel and Deluca (2007) postulated that unmet maternal expectations during the birthing process can lead to a sense of failure. Therefore, it is important to be open minded and flexible as this eases the transition for women into unplanned modes of delivery. Sharon explained *"I didn't really feel like having a birth plan was very realistic because it doesn't go according to plan. It is not a… it's not the type of thing you can really plan for… I didn't have like a detailed plan that I was expecting because I just didn't think that was um… I don't think that was really a good um thing to do for yourself and your mind when you are going into something that you know so little about… to have it laid out for you in a step by step plan and I just think cos that would lead to more disappointment."*

It was also expressed by participants that it is important to carry this notion of flexibility into their parenting style as it becomes helpful in the transition into motherhood. Natalie stated "*but I think that is what motherhood is also about. It is about learning you just can't control things and again that comes back to the birth. It was what was out of our control."* Participants who had more definitive birthing plans found the processing of their unexpected birthing experience more difficult. Further the use of *"our"* in Natalie's quotation further supports the above sub-theme of sharing of others' stories as it implies a shared, common experience.

From another perspective, some of the participants described a lack of control in relation to their birthing experience. A sense of passivity was tangible as participants describe the process of birth and labor particularly related to the induction. Induction is the process whereby labor is started through medical intervention (Mishanina, Rogozinska, Thatthi, Uddin-Khan, Khan & Meads, 2014). There were common feelings that medical intervention can often be disempowering and results in a lack of control over one's body. This idea is echoed by Harris and Ayers (2012) as their research indicated that deliveries that require medical intervention particularly emergency Caesarean deliveries are linked to Post Traumatic Stress Disorder in mothers. This perceived lack of control can often be associated with negative birthing experiences (Guittier et al., 2014). On the contrary, an increased sense of control is associated with higher level of maternal satisfaction with the birthing process (Ford et al., 2009). However, impingements on maternal agency are inevitable due to individual circumstances (Tully & Ball, 2013). In other words, mothers are unable to be fully in control of the birthing process as certain factors cannot be controlled. These factors differ according to the circumstances of the individual. Mothers and society in general perceive doctors as the voice of authority and have the power to make choices and this voice is very powerful in terms of decision-making for expectant mothers (Tully & Ball, 2013).

Some participants such as Tanya and Natalie experienced the relinquishing of control to the medical team as a positive and containing experience. Others such as Lisa and Sally

experienced it as more threatening and anxiety provoking. The latter tended to be related to difficulties with trust. Despite these differences, there appeared to be agreement amongst the participants that the process of giving birth is beyond one's control. One has to try and accept that certain aspects of the process are within one's control, while other aspects are not and this is where the need for guidance from medical professionals arises.

All participants alluded to the lack of options available to them for future birthing options after previously giving birth via a Caesarean section. Most of these women stressed that they would follow the advice of a medical professional due to certain risks associated with V-BAC. Lisa and Nadine stressed the need for informed decision making on modes of delivery which is empowering and allows women a degree of choice.

Theme Three: Health of the baby as priority

All six participants emphasized the importance of the health of their babies as a priority when giving birth. The participants felt as though the mode of delivery became irrelevant when their baby's health and well-being was at risk. They reported feeling extremely grateful that they delivered healthy babies. Tanya related, *"I was relieved to have a healthy beautiful baby."* Although some participants such as Nadine and Natalie expressed the existence of judgment and stigma in general around Caesarean section deliveries, they felt as though their feelings about this needed to be set aside in order to prioritize the well-being of their child. Tully and Ball (2013) stated similarly that mothers have a strong need to ensure the health and safety of their babies and that this shapes their decisions around medical intervention in relation to their birth. The prominent feelings of being grateful that their baby is healthy links to the value of medical intervention where necessary. Nadine commented in this regard *"I feel like I've been through an experience and it was lifesaving in the end because my daughter would not have come out like she did if I had tried to birth her naturally. So going through that, I can see the value in having something done."* This links to how Winnicott (1956) spoke about the ability of the mother in setting aside her own needs to ensure the health and well-being of her baby.

Theme Four: Expectations on women: the 'good enough mother'

Most participants relayed a need to be considered and seen by the researcher and society as the 'good enough mother'. The standards of the 'good enough mother' are often synonymous with perfection by society's expectations. When this maternal image is threatened, some participants seemed to revert to a more defensive style of relating in order to protect themselves from possible feelings of inadequacy which are difficult to process. This is then followed by a need to compensate in order to restore the title of being a 'good enough mother'. This was expressed by some participants who wanted to relay to the researcher that they are mothers who are willing to sacrifice their own needs to meet the needs of their child. Lisa reiterated that *"I asked the anesthetist what's the earliest I can get out of bed and as he said I can, I called the nurse because I knew at that stage, I had to get up to ICU. I didn't care about myself as such."* This links to how the image of the 'good enough mother' is painted in a certain light.

Connotations of 'good' mothers are related to unattainable ideals and include the need for the mother to be a source of constant unconditional love to her children and self-sacrificing (Lewis, 2002). This portrayal depicts the needs of the mother as being secondary to that of the child and denies any feelings of maternal ambivalence (Lewis, 2002). Ambivalence is particularly difficult to process as it is coupled with judgment around being a mother. To admit maternal ambivalence would open oneself to judgment and stigma (Lewis, 2002). Synonymous with the 'good enough mother' is the suppression of these ambivalent, and sometimes aggressive, feelings towards her children (Hoffman, 2003). The lack of expression of healthy maternal ambivalence by some participants seemed to also fulfill a similar purpose. Lewis (2002) advocated that maternal ambivalence is embedded within the transition into motherhood and that societies' inability to recognize this perpetuates a stigmatized vision of ideal mothering. The inability to own this ambivalence causes mothers to maintain this dominant view of society as their ambivalence exists in a space where it is not accepted and therefore cannot be recognized (Kruger, 2003). This societal pressure does not provide women with the opportunity to process their aggressive and ambivalent feelings toward their babies thereby rendering these emotions intolerable (Hoffman, 2003).

Debates around what constitutes motherhood arose amongst participants. Lisa felt that pregnancy and the bond with her baby that comes with that process defines one's role as a mother as opposed to the process of giving birth. She explained *"the process of birth didn't make me a mother. I had been bonding with him for the last nine months. That's what made me a mother."* While Sally felt as though the birthing process is more significant in defining one's role as a mother as she related *"part of being a woman and mother is kind of like going through the pain of birth and the experience of birth. That kind of defines your role as a mother."* This also implies that Sally felt as though becoming a good mother is linked to an experience of pain and surviving the birthing process. Thus it has been interesting to note that the idea of strength has become intertwined with what is considered to be a good mother. This need to be seen as strong is an important one and makes it difficult for some participants to accept outside intervention particularly during the birthing process. Embedded within the ideal mother stereotype is the concept that mothers are deemed to be omnipotent and compelling (Lewis, 2002).

When these standards of what society presents as the 'good enough mother' are not met, it appears as though feelings of guilt ensue, as only perfection is considered to be 'good enough'. Nadine articulated this feeling of guilt in a different way whereby she expressed a concern that her inability to meet the standards of the 'good enough mother' in the way she gave birth would in some way contaminate her baby. She expressed concern that by having a Caesarean section *"your baby is going to come out bad"* as she had in some way not provided the optimum birthing process to ensure the developmental needs of her baby are met. Not fulfilling the requirements of the ideal mother has the potential to leave mothers feeling as though they are deviant and abnormal in some way (Lewis, 2002).

All participants recognized the importance of the maternal role in the care and development of their children. Linked to this is a sense of profound responsibility. Sharon strongly felt as though her own well-being dictates the well-being of her family. This pressure impacts on maternal identity and re-enforces the load placed on women in the maternal role. Tanya admitted *"there's always expectations on moms… your mother*

molds you into who you are… she's the first person to love you. She builds you into who you are. There is huge expectation and a huge amount of responsibility for the mother." As a result she felt a sense of fear around her own potential capabilities as a mother while she was pregnant. This statement alludes to the pressure placed on women to feel competent in their role as mothers as they are faced with the responsibility of shaping their children into individuals. In order to achieve this, one needs to feel 'good enough' in this role. The feelings of guilt and inadequacy in relation to the role of being a mother arise out of a need to be deemed 'good enough' according to societal expectations (Lewis, 2002). However this caliber of mothering is not achievable and therefore failure is likely to follow. The implications of this are important to consider when the need to be seen as adequate is so prominent (Raphael-Leff, 2010). Entering into the new role of motherhood with an immense amount of pressure to be deemed worthy in the role has to have a significant impact on maternal identity. The constant attempts to meet unattainable standards perpetuate a maternal identity characterized by feelings of inadequacy.

4.1 The importance of the maternal body

Within this theme of needing to be 'good-enough' the participants seem to place great focus and attention on the maternal body and the role it plays in childbirth and labor. Stone (2012) highlighted the importance of the maternal body as she stated that the relationship between the mother and infant is based on the body whereby the infant relates to the mother as a bodily figure. The process of giving birth was described by the participants as one that is innate and natural. The maternal body has been given a certain degree of power in this image as the mother to be needs to relinquish her own control to allow the forces of her body to take over. The body is seen to be more potent in comparison to the mind as Tanya described *"your body is allowing* [the birthing process] *to happen."* Links were made within participants' narratives to the specific way female bodies are biologically formed in order to meet this task and therefore women have always given birth naturally. Lisa's words illustrate this, *"it is just the way we are built and what we are meant to do."*

Notions of feeling like a failure emerged when considering the implications of having a non-elective Caesarean section. Caesarian sections are regarded as a flaw in the maternal body. Sally expressed that her body failed in the birthing process and therefore she needed to have a Caesarean section; *"I just really felt like my body failed me."* The use of the word *"fail"* has specific implications in how mothers perceive themselves as inadequate. This inadequacy is related to not having fulfilled a task according to their own expectations and the expectations of others. Not only their bodies, but they too as individuals, have failed. Linked to this, some participants felt an unconscious need to compensate for this perceived lacking in maternal ability. This is related to detachment from emotions and the use of psychological defenses as previously discussed as well as the need to be seen as the 'good enough' mother.

The process of giving birth naturally is considered to be an important rite of passage in the life of a woman and is inextricably linked to maternal identity (Akujobi, 2011). Further reference to the body as having *"failed"* on some level represents a distancing from the self that serves as a protective factor. To view oneself as having *"failed"* is more difficult to process than conceptualizing a body that has *"failed".* Sally strongly expressed the importance for her of coming to terms with her own individual body and how she makes sense of what it can and cannot do. This links to an idea expressed by Verdult (2009) whereby he stated that this perceived failure needs to be mourned by the mother. A question also arises about the ownership of the maternal body which has implications for agency and control for the mother.

4.2: Natural as best

Many participants including Nadine, Lisa and Sharon felt as though a natural delivery is considered to be the global standard for birth delivery. Nadine even went as far as to make reference to the World Health Organization in this regard. Comments were made in the interviews that suggested that having a Caesarean was not a natural way of giving birth and therefore in some ways it was not considered to be healthy. Tanya stated, "*natural is the way it should be done and that's kind of like the benchmark of everything that's good and I don't know. Some people subscribe that if you don't reach that*

benchmark then you have in some way fallen short and um that affects your mode of parenting." Natural delivery is therefore viewed as the best mode of delivery for many of the participants. It appeared that some of the participants felt as though their mode of delivery in some way dictates the type of mother that they are. The above quotation also suggests that some women feel that there is a certain prototype of birth that exists which represents success and achievement and when this is not achieved there may be a sense of failure in the mother. Natalie voiced concern at how having a Caesarean section would impact her bond with her baby as she believes the birth process in itself is a form of bonding.

However, there was an idea amongst the participants that not all natural births are considered to be equal. At the top of the hierarchy seems to exist a delivery without pain management intervention. Sally and Nadine were open to the idea of having pain management medication in their initial birth plan if needed; while Lisa was adamant that she did not want to have an epidural due to its potential risks.

Nadine and Sharon experienced their antenatal coaches as presenting natural births as ideal, while undermining Caesarean modes of delivery. They felt as though the benefits of delivering naturally and the downfalls of having a Caesar were emphasized. Nadine and Lisa thought that potential mothers were lacking in knowledge around the different birthing options. Nadine strongly advocated the need for antenatal classes to provide information on different birthing options equally in order to allow potential mothers to make an informed decision on their own mode of birthing. The focus on natural delivery seems to take away from this opportunity.

Linked to this is the perception that a natural birth is seen to be an accomplishment. Natalie described her experience of almost being able to deliver naturally and then being told she needs a Caesarean section as an experience whereby *"I was very upset. I was very disappointed. Like here I was ok I have made it."* Guittier et al. (2014) echoed this idea as it was found that delivering vaginally is linked to feelings of accomplishment, self-worth and pride. Sally really struggled to come to terms with having a Caesarean

section and this profoundly impacted her transition into motherhood. She expressed "[the Caesarean section] *definitely didn't enhance* [the transition into motherhood]. *Um it definitely like added to it and the guilt. You know like coming to terms with what I had gone through and like getting over the sense like I didn't fail. It wasn't like a failure. I had a healthy baby and all that and trying to switch my attitude about that."* Thus the inability to have a natural birth also has implications for maternal identity and being considered by society and other women as a 'good enough' mother.

4.3: The Un-named judgment

All participants believed that there is a degree of judgment by other women, mothers and society in general placed on mothers and their mode of delivery. However the sense of feeling judged was very difficult to name. Nadine and Natalie struggled to engage with the meaning and motivation behind the judgment and perhaps the stigma becomes too difficult to experience and articulate. Lisa expressed strong cultural and religious views about modes of birthing and stated that women in her Jewish community *"don't believe it is right to have a Caesar no matter what. You have to go the way God intended."* Sally and Sharon seemed to group mothers into those who have delivered naturally and those who have had a Caesar by using terms such as "*one of those mothers*" or "*those girls."* This constitutes the psychological defense of splitting whereby participants attempted to distance themselves from other mothers who underwent a non-elective Caesarean section in order to cope with anxiety and sense of disappointment (Lemma, 2003). The psychological defense of splitting is particularly used to cope with overwhelming feelings of anxiety. It is interesting to note that this categorization occurs according to mode of delivery and it is argued that the implications of this in terms of reinforcing stigma are paramount. This categorization of mothers can also be interpreted as a means of distancing oneself from a group of people as a protective factor. A study conducted by Tully and Ball (2013) indicated that women who delivered via Caesarean deliveries were concerned about being labeled as 'too posh to push'. This suggests that the mode of delivery has implications for one's character.

Conflicting views in society around modes of delivery was highlighted as many of the participants expressed the notion of push and pull and the prominence of other peoples' opinions. Further, participants believed that judgment in this regard is inevitable. The opinions by other mothers are experienced as intrusive and place an enormous amount of pressure on potential mothers. Lisa felt as though women are encouraged to have Caesars through exposure to labor and birth via the media as natural birth in the media conjures feelings of fear. Nadine felt as though other mothers tend to pity those mothers who delivered via a Caesarean section and that the judgment around having a Caesar extends into motherhood, long after the birth of one's child. Women who are unable to give birth naturally are seen as being weak in some way and this relates to assumptions that exist around the concept of the 'good enough mother.' Therefore, the importance of being deemed 'good enough' by society and other women and mothers is inextricably linked to the process of maternal identity formation.

4.4: Maternal Lineage

A further sub-theme of the theme of expectations on women and the 'good enough mother' was maternal lineage. Participants Nadine, Sally and Sharon drew their own historical links and positioned themselves within a legacy of women who have delivered their children for thousands of years through natural deliveries. They made reference to ideas that birthing is a natural process irrespective of historical settings and therefore should continue to remain that way. Lisa explained *"our bodies have been doing it for years and years where it is what we are meant to do."* The use of the words *"our bodies"* indicates that there is something intrinsically embedded in the birthing process that links one to a legacy of women.

Ayers and Pickering (2005) discussed how maternal birthing expectations are shaped by a number of factors including aspects of their own childhood and their own exposure to modes of birthing. Many participants in the current study made reference to their mothers and sisters who had natural births and so assumed they would do the same. There seemed to be a familial narrative to live up to. Sally stated that she *"thought* [she] *would give birth the way my family did."* This is coupled with the idea of exposure and learning

through the experiences of others who one is close to. Sally added *"that's just what I knew."* Discussion of this sub-theme indicates that the expectation on women to be 'good enough' is linked to the lineage of one's family and women kind in general. The inability to be part of this legacy has an impact on maternal identity formation particularly in the form of feelings of inadequacy and isolation.

Theme five: The importance of support

Support is a key factor in easing the transition into motherhood. This is echoed by Ford et. al (2009) who reported that a high level of support during birth is linked to positive birth outcomes and maternal appraisal. This support comes from a variety of sources such as husbands, mothers and doulas. Lisa and Nadine had doulas during the birthing process and deemed this to be a positive experience. Doulas are individuals who are trained to provide information and emotional support to the mother during and after the birthing process (Backes-Kozhimannil, Hardeman, Attanasio, Blauer-Peterson & O'Brien, 2013). Nadine stated *"I had a doula as well which I found very beneficial to have and she was so great."* Doulas were also able to be supportive when husbands felt overwhelmed. Doulas assisted the participants in processing their individual birthing experience after the birth.

Women's own mothers also play a key supportive role during and after the birth.. Sally expressed the difficulties of not having her mother in the same country when she had her child. She expressed *"I really struggled in the beginning. Like it was very hard for me and like not having my mom here... You know it's just not the same. So it was a pretty rough transition."* Natalie admitted, *"Luckily I have a very hands on husband so between the two of us* [the transition into parenthood] *um it's been alright."* Sharon and Natalie explained the importance and benefits of a collaborative relationship with their husbands and how this has had a positive effect on their transition into motherhood. Research (Parfitt & Ayers, 2014) also indicates that the nature of the relationship between the two parents is a vital element when considering the transition into parenthood particularly that of first time parents. Low levels of support and a poor quality of relationship between partners is a key indicator in assessing the risk of development of post-partum depression

(Parfitt & Ayers, 2014). Support also becomes important for practical reasons in the recuperation after a Caesar. Extended social support is also imperative as Hennekom (2016) postulated that role models play an important part in easing the transition into motherhood for new mothers. Some participants highlighted the role of women in their communities who have been a source of encouragement and act as role models for them. Thus support is an important factor that eases women into their maternal role and aids maternal identity formation.

Theme six: The role of labor and preparation

Tanya, Sharon, Sally and Nadine relayed their initial emotional reactions about having a Caesar and then described the importance of having time to process these feelings before the Caesar is performed. This time to process one's experience is very important and seems to ease the transition into an unplanned mode of delivery. This was also indicated in research conducted by Tully and Ball (2013) in which participants found it useful to be given the opportunity to acquaint themselves with the idea and process involved in having a Caesarean section. Sharon explained *"like I was really really upset at the potential of having a Caesar and um, as the labor went on, I kind of um had some more time to wrap my head around the possibility…. And I kind of didn't really mind at that point but I really often think about how I would have felt if I didn't have that initial time to prepare."*

The majority of the participants also expressed the importance of trying to have a natural birth and how that was beneficial for them. This was especially the case for those participants who were given time by their doctors to try birth naturally. Nadine expressed that *"I think going through a process where you tried* [a natural birth] *and that was what you had to do; you can see the benefits in it."* This reflects that having a sense of control seems important for the participants in transitioning into motherhood. Research by Ford et al. (2009) also reflected that perceived control for mothers was found to be associated with easing the transition into motherhood and birth satisfaction.

All participants experienced some form of medical intervention to try and progress the labor. It seems that forcing the body to go into labor was unsettling for these women and they felt that their body should be allowed to progress naturally. Natalie explained *"pregnancy is natural and so should the labor be natural."* The labor itself is a powerful process as participants articulated its benefits for the baby's development. Further, the process of labor is an important rite of passage into motherhood whereby experiencing pain represents some form of achievement as a woman as previously discussed in this chapter.

The above discussion reflects the themes extracted from the interviews with the participants, namely emotion and psychological defenses; flexibility and control; health of the baby as priority; expectations on women: the 'good enough mother'; the importance of support and the role of labor and preparation. The desire to be seen as a 'good enough' mother colors many of the aforementioned themes and discussion. The notion of what is considered to be 'good enough' seems to be dictated by society, internalized by women and then translated into self-imposed expectations. The way women are perceived by society and themselves has implications for maternal identity formation in that women are left with feelings of inadequacy in the maternal role and therefore they need to compensate for this through the use of psychological defenses.

The strengths and limitations of the current study as well as the study's implications for future research will be explored in the concluding chapter to follow.

Chapter Six: Conclusion

Strengths and limitations of the study

The strengths of this study include the fact that is it is a qualitative design which was chosen as it was the researcher's intention to yield rich in-depth data in the pursuit of exploring the effects of a non-elective Caesarean section on maternal identity formation. This research paper has contributed to the existing body of knowledge on how birth experience is implicated in the construction of maternal identity. Results of the current study indicate that the desire to be viewed as a 'good enough mother' by society, as well as by other women is an important component in maternal identity formation and largely influences the mother's processing of the birthing experience and how she makes sense of her maternal role. Support during and after the birth is a vital component that aids the mother in the development of her maternal identity. Labor and preparation for the unplanned mode of delivery act as a useful transitional space for the mother. The current study has also served as a springboard for future research in an area which remains under-researched particularly related to the effects of unplanned modes of birth on maternal identity formation.

While one-on-one, individual interviews are a strength in the current study, in that they yielded rich in-depth data, they can also be considered a limitation. This is because interviews can make participants feel uncomfortable or vulnerable which might result in them becoming inaccessible or psychologically defended. However, the researcher experienced the participants as open and engaging. Participants may have felt uncomfortable to share such intimate and personal details with an individual they have just met. In order to address this possibility the researcher attempted to build rapport by asking non-threatening and non-intrusive questions first.

A further limitation involves the attempt to homogenize the sample and the chance that diversity was sacrificed. The sample only consisted of white females. However, this did not pose a major limitation in the findings as the researcher aimed to explore the birthing experience of the participants and how they individually make sense of this experience

and the process of their maternal identity formation. The researcher was also a first time mother and needed to remain cognizant about her role in the analysis of the data and aware of her own judgments and feelings on the topic in order to ensure the transparency of the findings. The researcher attempted to manage this through her personal ongoing psychoanalytically orientated psychotherapy and capacity for self-reflexivity.

Recommendations for future research

It would be useful to broaden this research topic to other racial groups and explore how maternal identity is constructed among different populations and across different class and economic groups in South Africa. More research needs to be conducted in the area of maternal identity formation in general, particularly focusing on maternal subjectivity given that this is a relatively under-studied field. This would include research on how women negotiate their feelings about their maternal role in light of societal and cultural expectations. It would also be useful to conduct research which focuses on maternal identity and breastfeeding. Particularly how women make sense of their ability or inability to breastfeed and how this ties into their self-perceived maternal identity. Maternal identity has significant implications for how women perceive themselves in their role as mothers and how this translates into their relationship with their babies. This research would be of benefit to women and various health professionals working with such women, including psychologists, midwives and doctors.

Conclusion

It is evident from the review of the pertinent literature on the topic of modes of birthing and maternal identity and the results of the current research study that women enter pregnancy and childbirth with certain expectations. Such expectations include the desire to give birth naturally, with or without pain management. These expectations have their roots in culture and society and what is deemed to be ‘good enough’ mothering. These expectations have significantly influenced how the participants have processed their own birth experience and maternal identity, particularly in light of having a non-elective Caesarean section. This was important to explore in order to address the research

question of how birth expectations and lived birthing experience are reconciled, or not, and internalized by first time mothers who gave birth through a non-elective Caesarean section. The notion of the 'good enough' mother is vital to consider in relation to the original research question of exploring societal expectations of the role of the mother and how this impacts on maternal identity formation. Important themes that emerged within the participants' narratives included the strong pressure placed on women by themselves and society to be seen as a 'good enough' and competent mothers. This colored how the participants were able to process their birth experience and transition into motherhood. The above provided insight into the initial research question of exploring the process of maternal identity formation of first time mothers who gave birth through a non-elective Caesarean section. It became difficult to name and engage with their emotions around their birth experience as by doing so it would have uncovered an underlying vulnerability to psychological pain. Participants also tended to share the stories of friends and family as a means to express more difficult emotions around the birthing process, including feelings of guilt and shame. While the wellbeing of the baby was deemed to be the top priority, participants felt as though there exists a negative judgment around Caesarean sections. Social support is an important factor that assisted the transition into motherhood, as well as a degree of flexibility with regards to the birthing process. Labor and time were also experienced as important factors in allowing the participants the opportunity to process giving birth through a non-elective Caesarean section.

The research process was both gratifying and challenging for the researcher. It was interesting to engage with different women about their own birthing experiences and how they negotiated their transition into motherhood. The interviewing of the participants gave the researcher insight into the challenges that women face particularly in relation to the expectations placed on them by society. This was an enlightening and humbling experience. It was sometimes challenging for the researcher to not allow her own birthing experience to shape how she engaged with the participants and consequently the data. This was something that the researcher needed to be constantly mindful of throughout the research process.

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Appendices

Appendix one: interview schedule

Demographic questions

Participant number:

Age:

Number of children:

Ages of Children:

Gender of Children:

Mode of delivery of each child:

Interview questions

1. Please tell me about your first birthing experience
2. How did you feel immediately after the birth about your birthing experience?
3. Did these feelings change over the next few weeks/months and if so, how did they change?
4. Did you have a birth plan/birth expectations for your first birth? If so, what was your birth plan/expectations and what made you choose this birth plan?
5. How did you feel when this plan did not come to fruition?
6. Please describe what type of mother you are
7. What do you feel is important to you in this role?
8. How did you experience your transition into motherhood?
9. Do you feel your birth experience enhanced or impeded your transition into motherhood? Please elaborate.
10. How do you understand society's and your culture's perceptions on motherhood and mode of birthing?

    Probe for participant's perceptions of society's expectations placed on her around giving birth

11. What do you think, if any, are society's expectations on different birthing options?
12. How do you make sense of these?
13. Please can you tell me about your subsequent birth experiences
14. Have your views/experiences changed? And if so, how?

Thank you for your time

Appendix Two: Participant information sheet



School of Human and Community Development

Private Bag 3, Wits 2050, Johannesburg South Africa

Exploring maternal identity formation of first time mothers who gave birth through a non-elective Caesarean Section

Dear Madam,

My name is Kim Lazarus and I am currently conducting research at the University of the Witwatersrand for the purpose of obtaining a Masters degree. I am conducting a qualitative research project which will explore maternal identity formation in first time mothers after a non-elective Caesarean section. The rate of Caesarean sections has rapidly increased in South Africa. Therefore, it is necessary to explore how this affects the development of a woman's identity as a new mother.

I am inviting you to participate in my study. If you agree, you would be required to partake in an individual interview with me, the researcher which would take approximately 45 minutes to one hour. I would like you to be aware that participation is completely voluntary and there will be no consequences if you decide not to participate. For analysis reasons, the interview will be tape-recorded, however, only my supervisor and I will have access to these tapes. Once the information has been transcribed verbatim, the transcripts will be stored on a password-protected laptop. The audio recordings will be deleted after the completion of my degree. You will be asked for permission for storing the anonymized transcript for possible future research use. Your identifying information will not be mentioned in the study ensuring confidentiality and

anonymity. I will assign a pseudonym to all the participants. You have the right to withdraw from the study at any stage without consequence. You will also not be required to answer any questions that you do not wish to.

Once the study has been completed, you are able to request a summary of the findings. This should be available six months after the data collection. The contact details of my supervisor and myself are provided below. If you feel that the interview has elicited an emotional and sensitive response in you, you are welcome to contact a local clinic whose number has also been provided in this letter. You will then be able to utilize the free counseling that is available:
Emthonjeni Centre (University of the Witwatersrand) 011 717 4513
If you prefer to seek private psychotherapy, I will provide you names and contact information of psychotherapists upon your request.

Before the interview will commence, I will ask you to read through and sign the consent form and detach it from this letter. This form will confirm that you understand what is required of you and the confidential nature of the study.

Should you require any further information, please feel free to contact me or my supervisor.

Your participation would be greatly appreciated

Kim Lazarus
Email address: kylazarus@gmail.com
Telephone: 082 555 1075

Clare Harvey (Supervisor)
Email address: clare.harvey@wits.ac.za
Telephone: 011 717 4509

Appendix Three: Participant Consent Form



School of Human and Community Development

Private Bag 3, Wits 2050, Johannesburg South Africa

Exploring maternal identity formation of first time mothers who gave birth through a non-elective Caesarean Section

I, _____, consent to taking part in the interview conducted by Kim Lazarus, for her study exploring maternal identity formation of first time mothers who gave birth through a non-elective Caesarean section.

As a participant in the study, I understand that:

- My participation is voluntary
- I am free to withdraw from the study at any time
- I do not have to answer any question(s) that I do not wish to
- My identity will be protected from the final research project and therefore my final anonymity is ensured
- I may be quoted in the final report but this will be under a pseudonym given to me
- The results of this study will be used in the research report that is required for the completion of a Masters degree in Clinical Psychology
- I understand that the interview will be recorded but access to this information will be confined to the researcher and research supervisor
- The recordings and transcripts will be stored on a password-protected laptop

Please tick the appropriate box:

I consent to audio-recording

Yes ☐

No ☐

I consent to my anonymized transcript to be stored for possible future research use

Yes ☐

No ☐

Date:_____

_____

Signature of participant

Thank you for your time

Supervisor contract

Electronic copy saved to disc

Ethics Approval

Electronic copy saved to disc