‘Plan Z and then off the edge of a cliff’: an interpretative phenomenological analysis of mothers’ experience of living with a slow-to-heal Caesarean wound

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Abstract

Background Studies indicate that complex postsurgical wound healing can significantly alter biopsychological markers responsible for recovery, such as pain perception and sense of self-coherence. Yet, there is a lack of research investigating women’s experience of living with slow-to-heal Caesarean wounds, as a complex phenomenological procedure combining surgery and childbirth. This is an important area of investigation considering the increase of factors associated with surgical births and poor wound healing in the UK and globally.

Aim The aim of this study is to explore women’s experiences of living with a slow-to-heal Caesarean wound.

Method Semi-structured interviews were conducted with seven women who had lived experience of slow-to-heal Caesarean wounds. Narratives were analysed using Interpretative Phenomenological Analysis (IPA) approach.

Results Analysis of women’s narratives revealed three interlinking superordinate themes of 1) Tied to that event’: healing physical and emotional wounds, 2) The ‘good mother’ and the ‘good patient’: negotiating being a carer and being cared for, and 3) ‘Adjusting to a new normality’. Overall, slow-to-heal wounds embodied women’s perceptions of agency over their Caesarean birth experience and achievement of a new motherhood identity. Wherein, successful healing would encompass a sense of normality defined by subjective notions of regaining expected roles and daily activities, previous bodily functions, and maternal status within their families that became disrupted due to delayed wound healing.

Conclusion Women’s narratives support discourse surrounding Caesarean birth and recovery as a biopsychosocial phenomenon. This has important ramifications regarding research and treatment programmes for postnatal women with complex healing that are largely described as ‘invisible’ in literature. In this regard, findings suggest a prominent role for health psychologists in directing psychosocial education intervention and support at both patient and organisation level.

Glossary

BMI: Body Mass Index, measure using height and weight to calculate if a person's weight is healthy, a BMI of over 30kg/m^2 is classed as obese.

CB: Caesarean birth, birthing procedure wherein the baby is delivered via a surgical cut made in the abdomen and uterus

CDMR: Caesarean delivery on maternal request, Caesarean request based on maternal preference with no underlying medical reason.

Dysesthesia: abnormal sensation (i.e. burning, itching) and reactivity to touch, usually due to peripheral nerve damage.

HELLP syndrome: pregnancy complication which is a form of severe pre-eclampsia, characterised by haemolysis (H), elevated liver enzymes (EL), low platelets (LP).

Hyperalgesia: increased sensitivity to pain, usually due to nerve damage.

Lactogenesis/ lacto production: process of mammary glands development in breasts responsible for milk production and secretion.

Laparoscopy: Caesarean scar revision technique

Necrotising fasciitis: bacterial infection that can result in the death of the body's soft tissue that is affected.

PROM: Patient reported outcome measures, usually a self-report survey designed to capture patient's health related quality of life following a surgical procedure, in order to assess quality of care.

Puerperal: the period immediately after childbirth during which the uterus returns back to its original size

SSI: Surgical Site Infection, post-surgical infection in part of the body operated on

Uterine niche: Also referred to as an isthmocele or caesarean scar defect, an indentation in the uterine wall with a depth of at least 2mm due to incomplete Caesarean incision healing.

VBAC: Vaginal birth after Caesarean.

Venous ulcer: open sore in the skin that is slow-to-heal, caused by disrupted blood flow in leg veins

Wound dehiscence: partial or total separating of wound edges, due to poor wound healing.

Terminology

Note surrounding medical terminology- This study uses the terms slow-to-heal, hard-to-heal and complex healing interchangeably to describe postoperative wounds that have failed to heal in a timely manner. In-depth discussion surrounding the parameters of this definition can be found in section 1.3.1 (p. 19)

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Note surrounding gender terminology- It is recognised that not all people that give birth identify as female. However, this study purposely uses the terminology ‘women’ and ‘mothers’ in line with existing literature. It is anticipated that findings from this study can be applicable and useful to all people who give birth and can pave the way for further examination into the needs of under-researched members of the population.

Additionally, this study uses the term ‘patient’ interchangeably with ‘women’ and ‘mother’ in parts. It is acknowledged that describing expectant or new mother as ‘patients’ undermines women’s authority and assumes a paternalistic position which pathologises childbirth (MacLellan, 2020). This term is used in this study to aid reader understanding as discussions cross over with literature surrounding generic patients living with a wound.

1 Introduction and review of literature

1.1 Introduction to Caesarean births and wounds – a biopsychosocial perspective

Caesarean section is a surgery that involves making an incision on an expectant woman’s lower abdomen and uterus in order to deliver one or more babies (National Health Service, 2020). Whilst Caesareans used to be performed for purely medical reasons, recent medical advancements and changes to guidelines have led to Caesareans becoming part of the patient choice agenda in the UK and globally (Wise, 2018; D’Souza & Arulkumaran, 2013; D’Souza, 2013; Jones, 2012). Studies have illustrated that whether planned or unplanned, Caesarean births (CB) are complex biopsychosocial experiences, in that the procedure is a juxtaposed combination of the milestone event of childbirth and undergoing invasive surgery (Wollny *et al*, 2021; Coates, Thirukumar & Henry, 2019).

Though Caesareans are increasingly regarded as a common and safe procedure in high- and medium-income countries (Keag, Norman & Stock, 2018), there are risks associated with CB as with all types of surgeries. For example, post-Caesarean surgical complications such as wound dehiscence can occur in up to 5% of cases following discharge, with up to two thirds of these open wounds becoming infected, thus impeding the organic wound healing process even more (Quinlan & Murphy, 2015). Surgical Site Infections (SSI) are the most cited post-surgical morbidity and can occur with or without wound dehiscence (Zuarez-Easton, Zafran , Garmi , Salim, 2017). A comprehensive systematic review and meta-analysis of literature published between 1992 and 2016 reported post-Caesarean SSI rates between 5%-15% (Saeed, Greene, Corcoran & O'Neill, 2017), but a more recent study cited rates as high as 20% (Gomaa *et al*, 2021). Additionally, more than 75% of post-natal wound infection incidences occur post discharge when women are settling into new maternal routines (Childs *et al*, 2020). This indicates requirement for further medical attention and disruption to patient lives during what is arguably an important transitional event for new mothers (Sandall *et al*, 2018; Quinlan & Murphy, 2015; Sarsam, Elliott & Lam, 2005). In the UK, women are transferred from midwifery into health visitor care provision around 10-14 days after birth (NICE, 2021). The National Institute for Health and Care Excellence (NICE, 2021) recommendations stipulate that whilst health visitors should continue to check post Caesarean wounds, it is not within the health visitors’ remit to assess and treat medical concerns. Rather, women should be referred and signposted to appropriate health care professionals for further treatment. It is worth noting that NICE (2021) critiques postnatal care in the UK as a ‘Cinderella

service' characterised by disjointed patient pathways, and lack of handover or case information sharing between professionals involved in the new mothers care. This suggests that there are inequalities in relation to the treatment and support received by women presenting with post Caesarean complications. Additionally, formal postnatal care is discontinued following the routine 6-8 week check-up (NICE, 2021); meaning women who obtain or suffer from continuing wound morbidity past this time frame may be at greater risk from preventable outcomes.

Currently, there is a paucity of research on the postoperative experiences and needs of new mothers who give birth via Caesarean, due to maternity care focus on safe deliveries (Benson & Wolf, 2012). A simple literature search using keywords 'C*sarean' and 'recovery' delivers a plethora of articles relating to Enhanced Recovery After Surgery (ERAS)- a set of guidelines promoting accelerated recovery centring around clinical constructs such as postoperative analgesics, urinary/bowel functioning, etc. However, there is a clear lack of research regarding how women experience these clinical factors (Wollny *et al*, 2021). Thus, one can question how acceptable, effective or applicable postoperative interventions are for the patients they are designed for.

The recent decade has seen an increase in academic interest encompassing psychosocial aspects of complex wound healing, further exacerbated by dialogue surrounding patient care during the Covid-19 pandemic (Sen, 2021) . Nevertheless, there is a void in studies inspecting post Caesarean maternity populations with this issue. This is important and warrants further research since there is robust evidence that postnatal morbidity impedes mother-infant bonding and other factors important in attachment building (i.e. breastfeeding; Quinlan, 2019). This has negative long-term consequences, for example, reduced maternal emotional regulation can impact negatively on the infant's future relationship styles as an adult (Reisz, Brennan, Jacobvitz & George, 2019). Additionally, the increase of risk factors associated with delayed Caesarean recovery means the economic burden of treating these slow-to-heal wounds can become an emerging problem for the UK healthcare system as well (Childs *et al*, 2020; Bullough *et al*, 2015).

This chapter is divided into two main sections. The first part introduces readers to an overview of CBs framed using a biopsychosocial approach (Engel, 1977); or the interaction between biological, psychological, and social determinants of recovery from a CB. The second part considers the biopsychosocial meaning of living with a slow-to-heal postoperative wound in the context of CB. The aim of this chapter is to enable the reader to gain a rich perspective of the research question being investigated: What are the experiences of women that have been, or are living with slow-to-heal Caesarean wounds?

1.1.1 Background and problem statement

Research on patient experience with poor healing wounds has largely focused on older population groups living with chronic leg ulcers, and more recently, patients living with acute wounds from general surgery (Fearns, Heller-Murphy, Kelly & Harbour, 2017; Alexander, 2013). However, there is a noticeable lack of published studies investigating women's experiences of recovering from Caesarean wounds that are slow-to-heal, despite the known psychological implications of giving birth via surgical intervention (Lusher & Djatmika, 2020). This licenses investigation, due to the growing trend of birthing by Caesarean surgery and the increase of risk factors associated with unsatisfactory CB outcomes (Słabuszewska-Jóźwiak, Szymański, Jóźwiak, & Sarecka-Hujar, 2021; Lusher & Djatmika, 2021). Approximately 29% of birth deliveries in the UK are now done by CB,

with this prevalence increasing (NHS Digital, 2022). This figure is markedly higher than the 15% cut off point advocated by the World Health Organisation (Wise, 2018; Betrán *et al*, 2016). Furthermore, statistics indicate that there are inequalities in CB outcomes that are influenced by the complex interaction of surgical and patient risk factors. An example of the latter is the growing prevalence of women presenting as being over-weight in pregnancy, with the rate of gestational obesity doubling between 2010 and 2018 (22% and 44% respectively; Childs *et al*, 2020). This is concerning, as having a higher body mass index (BMI) and associated co-morbidities (i.e. diabetes) are risk factors for poor postsurgical wound healing (Plassmeier, Hankir, Seyfried, 2021; Pierpont *et al*, 2014). For obese women who have a BMI > 35 kg/m^2 that have given birth via Caesarean, the risk of SSI can increase to around 20% (Bullough *et al*, 2015; 2014), which is more than double the average rate of approximately 10% in Wloch *et al's* (2012) study. These rates are comparable to SSI statistics associated with 'dirty' surgical procedures such as bowel surgery which is around 15% (Wloch *et al*, 2012). With the national increase of obesity and diabetes, the complications associated with these comorbidities following a CB will become a growing problem for the NHS (The Scottish Government, 2021; Childs *et al*, 2020; Bullough *et al*, 2015).

1.1.2 Rationale for the biopsychosocial approach

This current study adopts a biopsychosocial approach in understanding women's lived experience of slow-to-heal Caesarean wounds. The biopsychosocial model was initially proposed by Engle in the 1960's in response to the biomedical framework, which posits poor health as the product of physical disorder, remediable by physicians identifying and treating the source of biological malfunction. Engle extended the biomedical framework to include social and psychological elements, suggesting patients' interaction with their own lived world as contingent in biological response to illness (Farre & Rapley, 2017; Borrell-Carrió, Suchman & Epstein, 2004). This is relevant to the current study guided by health psychology principles, which recognises a whole person approach when considering latent factors associated with illness and injury trajectory (i.e. aptitude towards health protective behaviours; Sarafino & Smith, 2011).

The obstetric field is particularly relevant to this; childbirth and the early postpartum period is hallmarked by fluctuating hormones associated with a physiological response to emotive processes that impact recovery, such as pain and social support. Saxbe (2017) further explicates that clinical intervention during birth (i.e. Caesareans) can disrupt this intricate immunological system. Yet despite this, there is a paucity of research which adapts a biopsychosocial framework in this domain. This is a significant oversight as there is evidence that the biopsychosocial approach has been paving the way towards improved patient centred care both in the field of midwifery and wound healing. As a specific example, Guttormsen & Chadwick (2015) explored a case study of a patient with a diabetic foot ulcer to illustrate that amputation may have been avoided if the healthcare team had adopted a biopsychosocial approach that, for instance, recognised and addressed the patient's perception of stigma associated with his substance misuse as an underlying reason for not engaging with preventative health services. As another example, an overview of nine systematic reviews and meta-analyses published between 2009 and 2019 identified interactive psychological risk factors underlying couples' sexual dysfunction following childbirth, thus making a strong case for a biopsychosocial approach in tailoring interventions. (Hajimirzaie *et al*, 2021).

1.2 Caesarean Births- an overview

Caesarean surgery can be a necessary, lifesaving procedure, contributing towards improved childbirth mortality rates over the years (Keag, Norman & Stock, 2018). However, there is recognition that factors such as maternal older age, higher BMI, health co-morbidities (i.e. Diabetes), ethnic minority background, immigration and socioeconomic status are all characteristics associated with inequalities in terms of CB statistics and outcomes (The Scottish Government, 2021; Miani *et al*, 2020; Essex, Green, Baston & Pickett, 2013). These findings suggest that changes to population demographics in recent years, particularly in Western societies, are responsible for the increase in surgical births trends (Merry, Vangen & Small, 2016; Merry, Small, Blondel & Gagnon, 2013; Essex, Green, Baston& Pickett, 2013). However, wider psychosocial factors such as changes to societal birthing norms and medical practice have also been recognised as influences driving Caesarean rates (Jolly, 2017; D’Souza, 2013). The ‘normal’ or ‘natural’ birth movement was configured in the UK in the early 2000s in response to the increase of Caesarean births, which became a public health concern due to the potential socioeconomic costs and health harms of surgical births in comparison to vaginal births (Kennedy *et al*, 2010). The World Health Organisation’s (WHO) 15% cut off rate for medically necessary CB popularly cited by studies was based on global findings, with rates going beyond this percentage indicating preventable surgery that does not markedly improve mother-infant morbidity and mortality rates (Wise, 2018; Betrán *et al*, 2021;2016). Recently, the WHO has revisited recommended targets based on criticism that the guidelines have not been updated to reflect changes to women’s childbearing trends (i.e. women choosing to have children at an older age) and are therefore no longer realistic. Furthermore, existing studies are mostly critiqued as lacking methodological rigour; meaning conclusions cannot be ascertained. As an example, researchers highlight that findings are confounded by quantitative results that are derived from small, homogenous samples which are not separated according to whether the Caesarean was planned or unplanned (Leow, Tan & Black, 2021; Robson & Costa, 2017). It is argued that this differentiation is important as the post-surgical outcomes and experiences of women who undergo unexpected surgery due to underlying morbidity or medical necessity will vary in comparison to those that have expected or even elected the surgery (Lobel &DeLuca, 2007; Clement, 2001).

This theory will be discussed further below.

1.2.1 Caesarean Births: aetiology and classification

A significant challenge faced by researchers and policy makers lies in measuring and understanding the impact of Caesarean births, due to lack of standardisation of terminology and clinical definition (Leow, Tan, & Black, 2021). A systematic review identified twenty-seven Caesarean classification systems that can be broadly grouped into four categories based on clinical need, degree of urgency, patient characteristics and other classifications such as surgery circumstance (Torloni *et al,* 2011). However, in literature, Caesareans are commonly simplified into two categories based on whether the procedure was planned or not.

1.2.1.1 Unplanned Caesarean

Unplanned Caesarean are often labelled under the umbrella term emergency Caesarean to define surgery that was performed before or after labour in response to medical need. However, there are differences in unplanned CB outcomes; with women that have had Caesarean surgery

following a lengthy labour, failed assisted vaginal birth, or who underwent general anaesthesia reported as having worse postpartum morbidity (Landau & Richebé, 2021; Orovou *et al*, 2020; Lobel & DeLuca, 2007; Clement, 2001). Various reviews on the topic, including a mixed methods systematic review incorporating sixty six articles published between 1998 and 2018, conclude that psychological and physical postnatal functioning is significantly disabled following an unplanned CB. Qualitative components of the review illuminate how unplanned CB prognosis is contextualised within the complex psychosocial experience of delivering life while simultaneously dealing with a potentially life-threatening situation necessitating emergency intervention (Benton *et al*, 2019). In this regard, researchers such as Yang and Sun (2017) postulate that poor pre-surgical health status underlies increased risk for needing emergency surgical birth and resulting postpartum morbidities. Using the biopsychosocial theory as a framework, these findings can be explained by the interrelation between biological risk factors (i.e. maternal age), coupled with the psychological implications of undergoing a traumatic event (i.e. stress) and additional factors associated with unexpected surgery (i.e. lack of healthcare staff preparation; Coates, Thirukumar & Henry, 2019; Yang & Sun, 2017).

1.2.1.2 Planned Caesarean

The terminology elective Caesarean or Caesarean delivery on maternal request (CDMR) is regularly used to insinuate that it is women's demand and preference for surgical birth that is driving the increased rates of CBs (Miesnik & Reale, 2007). The mantra 'too posh to push' was coined in the 90's in response to statistics implying that there are inequalities in access to CBs, with women of higher socio-economic status more likely requesting and being granted CBs (Weaver & Magill-Cuerden, 2013). Media glamorisation and biased reporting of Caesareans further cemented the stereotype of women that elect Caesarean births as wanting 'the easy way out' or subscribing to chauvinistic standards by prioritising sexual function (Colomar *et al*, 2021; Keag, Norman & Stock, 2018). Notably, studies on women's reasons for having a CB have revealed that the term CDMR or elective Caesarean is over-simplified and further stigmatises many women that have elected a Caesarean due to perceived need, be this medical or psychological (Gamble & Creedy, 2000). For example, according to the National Sentinel Caesarean audit (Thomas & Paranjothy, 2001), repeat Caesarean's account for 29% of CBs with trend analysis indicating this rate had doubled significantly, as risks associated with having a natural birth following a Caesarean (i.e. uterine scar rupture) increases with each pregnancy. It should be noted that repeat CB procedures are generally more complicated to perform due to the presence of residual scar tissues (Sung & Mahdy, 2022; Rashid & Rashid, 2004), and are also associated with increased scar hyperalgesia (Ortner *et al*, 2013). This is important in the context of this study as duration and complexity of surgery (Plassmeier, Hankir, Seyfried, 2021; Jin *et al*, 2016; Peters *et al*, 2007) and postoperative acute pain (Chen *et al*, 2021; Pediani, 2001), are popularly cited as risk factors for poor post-surgical wound healing

For the purpose of this thesis, the terms unplanned and planned Caesarean will be used to describe whether or not the procedure was anticipated by the woman giving birth.

1.2.2 Towards a biopsychosocial understanding of slow healing Caesarean wounds

The deleterious impact of slow-to-heal or chronic wounds on patients', their families' and caregivers' quality of life is widely recognised in literature (i.e. Pađen, Griffiths & Cullum, 2022; McCaughan *et al*, 2018; Fearns, Heller-Murphy, Kelly & Harbour, 2017; Pinto *et al*, 2016). For

example, a narrative synthesis of more than fifty studies exploring the psychosocial impact of post-surgical complications evidences a strong association between delayed post-surgical recovery and impaired quality of life domains. In this review, the authors allude to the psychoneuroimmunology model to explain persistency of these results in long term studies, by hypothesising that the negative affect of slow healing wounds compromises protective biological and psychological mechanisms responsible for physical wellness. Furthermore, the authors highlighted misalignment between constructs healthcare staff report as important indicators of successful healing, versus markers that patients perceive as impacting on adjustment and well-being, such as body image (Pinto *et al*, 2016). There are strong similarities to biopsychosocial understandings of postpartum recovery; for example, findings from an integrative review of articles covering women's experience of obstetric anal sphincter injury suggest that healthcare professionals focus on clinical measures (i.e. pelvic floor exercise) and pay little attention to the psychosocial consequences of the wound. Again, body image is used as an example in this review with results highlighting how childbirth injuries can alter women's sense of self by disrupting sexual or reproductive identity (Darmody, Bradshaw & Atkinson, 2020).

Furthermore, qualitative studies exploring the recovery experiences of women with birth injuries and generic postoperative patients, identify that participants with more complex circumstances (I.e. poor wound healing, caregiving responsibilities), need information and treatment that surpasses generic provision. These studies generally conclude that this is an area requiring further systematic investigation (Finlayson, Crossland, Bonet & Downe, 2020; Tanner *et al*, 2012; Kealy, Small & Liamputtong, 2010). One example is the nuanced voice of a CB participant in Tanner *et al's* (2012) qualitative study exploring postoperative patients' experience of SSIs. This participant extract offered a different dimension to the collective narrative of psychological distress resulting from an SSI, contextualised within discourse surrounding postnatal depression. Thus suggesting divergence in experience, patient needs and long term outcomes. Similarly, a qualitative study exploring Iranian mothers' experience of perineal healing highlighted differences between the experiences of participants with minor versus major injury requiring longer healing duration (Jahanishoorab, Mirteimouri, Taghipour, Latifnejad Roudsari, 2019). The authors concluded that the narratives of those living with more complex wounds were distinguishable by underlying themes of loss of hope and despair. Additionally, Kealy, Small & Liamputtong's (2010) qualitative study investigating women's experiences recovering from a CB in Australia identified how surgical related complications reported by a proportion of interviewees bought to surface divergences and inequalities in terms of women's post-CB experiences and needs. Furthermore, qualitative studies demonstrate how '*minor*' setbacks and wound complications such as SSI's can have a significant impact on recovery indicators, such as emotional health, resilience, and body image (Kisa, & Zeyneloğlu, 2016; Pinto *et al*, 2016).

Despite these findings, there is a notable lack of focused research into the needs of new mothers negotiating multiple roles while living with slow-to-heal post-Caesarean wounds, in particular if healing extends past what can be considered an 'acceptable' time period for those already struggling to come to terms with their unwanted Caesarean birth. This is an important area for further consideration, as the physical, emotional, and financial debility caused by CB wound complications could, arguably, exacerbate the existing pressures and challenges of mothering a new-born, as well as disrupt other psychosocial markers responsible for maternal adjustment.

1.2.3 Prevalence of delayed surgical wound healing following Caesareans

Under usual circumstances, an uncomplicated Caesarean surgical wound typically heals within 8 to 14 days (Bullough, 2016;2015;2014). The healing end point is marked by organic tissue formation, resulting in joining of the wound edges, or in some cases; removal of non-dissolvable materials such as staples (Bullough, 2014; Nobbs & Crozzier, 2011).

There is wide variance in the prevalence of CB wound complications reported in literature, ranging from 2.8% -26.6% (Sarsam, Elliott & Lam, 2005). According to a surveillance study involving more than eleven UK maternity Trusts, (Ward, Charlett, Fagan, Crawshaw, 2008), around 14% of Caesarean surgical wounds becomes problematic and need further medical intervention. Furthermore, as most infections and complications occur post discharge, statistics associated with delayed healing are likely to be an underestimate (Childs *et al*, 2020; Ward, Charlett, Fagan, Crawshaw, 2008).

Due to lack of appropriate control measures in studies, there is also continued debate surrounding the accuracy of these birth related findings. For example, robust systematic reviews and meta-analyses indicate that the prevalence of certain morbidities, such as urinary incontinence, is higher in vaginal births compared to Caesarean deliveries. However, this risk is counterbalanced by higher infection rates, prolonged recovery and maternal death following a CB (Keag, Norman & Stock, 2018; Mascarello, Horta, & Silveira,2017; Miesnik & Reale, 2007). Additionally, even though the prevalence of urge urinary incontinence (urgent, uncontrollable need to urinate several times a day) is lower in CB populations, those that are impacted score lower in quality of life (QOL) indicators in comparison to mothers who acquire this condition due to an assisted vaginal birth. One proposed explanation for this phenomenon is that women that have had a CB did not anticipate urge urinary incontinence (Van der Woude, Pijnenborg, Jolanda de Vries, 2015), thus further strengthening the argument that the prevailing biomedical approach alone cannot explain and predict postnatal wound recovery trajectories.

1.2.4 Psychosocial impact of Caesarean births on postpartum recovery: ‘The Silent Mothers’

Postoperative recovery has been described by Borrell-Vega *et al* (2018), as the ‘*multifaceted experience of regaining control over multiple domains of function, including physical, psychological, physiological, social, and economic aspects’* (p. 259). In other words, the concept of postoperative recovery is not easily measured or clinically defined due to the patient’s idiographic journey in returning to their previous baseline state, and their satisfaction with this process.

In regard to the postpartum mother, the concept of recovery is even more complex and difficult to define as the transition to motherhood is characterised as physical and emotional congruity to a new state of ‘normality’, marked by significant hormonal, social and lifestyle changes (Sultan & Carvalho, 2021). The term ‘silent mothers’ or ‘vanishing mothers’ popularly used in literature relates to the shift of focus from the woman giving birth to the new-born infant, both from a societal and research perspective (Sega, Cozart, Cruz, & Reyes-Foster, 2021; Albers, 2000; Shoorab, Mirteimouri, Taghipour, Latifnejad Roudsari, 2019). To illustrate, most generic postoperative patients are treated with illness cognizant behaviours such as sympathy. On the contrary, post-Caesarean mothers are expected to be grateful and facilitate demanding traditions such as hosting visitors to welcome the new arrival (Landau & Richebé, 2021; Bayes, Fenwick, J &

Hauck, 2012). In research terms, 'silent mothers' relates to the paucity of literature on postnatal population groups (Alexander & Bouvier-Colle, 2001). For example, a recent review exploring risk factors for postpartum stress identified 18 articles with a focus on postnatal risk factors compared to 30 and 40 articles covering pre-pregnancy and intrapartum risk factors respectively (Simpson, Schmied, Dickson & Dahlen, 2018). Moreover, a systematic scoping review including 136 articles investigating postnatal health related functioning found that most studies focused on indirect consequences such as incontinence. Furthermore, the authors assessed most of the studies as poor quality and lacking methodological rigour, for example nearly half the studies did not include a suitable control group (Machiyama *et al*, 2017). Another systematic review found that there are no high-quality Patient-Reported Outcome Measures (PROM) that capture physical function more than twenty-five hours post Caesarean, further accentuating the gap of knowledge in this area and limitations in understanding of women's needs (Sharawi *et al*, 2019).

Additionally, the postnatal period is described as a time of '*hidden morbidity'* (Sharawi *et al,* 2019; Fahey & Shenassa, 2013); compounded by under-reporting of postpartum malaise due to the primal focus on the infant, lack of awareness of abnormal postnatal symptoms and shame in admitting dissatisfaction or embarrassing physical ailments such as faecal incontinence (Semasaka *et al*, 2019). In their article, Fahey and Shenassa (2013) enhance understanding of the topic matter in explaining that postpartum recovery is contingent on domains unique to this population group, such as attainment of expected maternal roles, which is not accurately captured by generic PROMs. In this regard, psychosocial sequalae specific to CB will be discussed further below.

1.2.5 Satisfaction with Caesarean birth and recovery

Postoperative satisfaction can be described as the alignment between the actual experience of recovery and preconceived expectations (Jaensson, Dahlberg & Nilsson, 2019; Borrell-Vega, Humeidan & Bergese, 2018). Studies suggest that the overall patient experience, such as quality of person-centred care received, degree of involvement in shared decision-making, and health literacy levels mediate the patient's satisfaction with their recovery journey (Atkin *et al*, 2019; Pereira, Figueiredo-Braga & Carvalho, 2016). Similarly, despite being a neglected area, there is strong evidence that women's early postpartum experiences are an integral part of an idiographic birth schema internalised by women (Falk, Nelson & Blomberg, 2019). For example, one study evidenced how women's satisfaction with their birth delivery was associated with postpartum factors such as perceived ability to control pain levels and mobility after birth (Karlström *et al,* 2007).

Patient satisfaction is recognised as an important field for investigation due to the associations with quantifiable recovery outcomes across both obstetric (Graham, Lobel & DeLuca, 2002) and wound care studies, i.e. hospital re-admission rates (Clement, 2001). To put simply, studies suggest patient satisfaction is linked to quality of postoperative wound healing and visa versa; in that patients whose wounds are taking longer to heal are more likely to report dissatisfaction with their recovery as a holistic concept (i.e. the Bluebelle Study Group, 2017). In terms of postpartum women, this is of importance, as birth dissatisfaction has been associated with disrupted bonding and reduced protective behaviours such as breastfeeding, hence having a long-term impact on mother-infant health and well-being (Chabbert, Panagiotou & Wendland, 2021; Lobel & DeLuca, 2007). Variations underlying Caesarean recovery dissatisfaction are multifactorial and transgress dialogue surrounding whether the procedure was requested or not, as discussed further below.

1.2.5.1 Loss of control

In their qualitative study exploring the experiences of mothers who had HELLP syndrome (somatic symptoms associated with blood or liver conditions) during pregnancy, Furuta, Sandall and Bick (2014) used Kidner and Flander-Stepans' (2004) three categories of loss of control as a framework to explain women's satisfaction with CB and recovery.

1. Loss of control over a meaningful life event:

Feminist scholars posit that expectant mothers are lulled into a false sense of agency when entering antenatal services (i.e. birth plan practice; Lobel & DeLuca, 2007). For the most part, women in high- and middle-income countries desire and expect to have a vaginal birth despite the increasing trend of giving birth via Caesarean (Loke, Davies & Mak, 2019; Mazzoni *et al*, 2011). A National audit undertaken in 2001 revealed that only 7% of women underwent a CB based on maternal request, compared to approximately 25% of women whose births result in a Caesarean procedure (Thomas & Paranjothy, 2001). Furthermore, according to Fenwick, Holloway and Alexander (2009) this figure is an over-estimate as the audit did not distinguish those that had requested a CB due to medical indication. The negative impact resulting from relinquishment of plans and expectations surrounding childbirth as a meaningful event are well recognised. For example, in their study findings, Alderdice *et al* (2019) reported that perceived maternal control was the strongest mediator between mode of birth and postpartum morbidity. Furthermore, studies have established that women's birth narratives are not restricted to the delivery room, but rather encompass women's wider intra-partum experiences, including perceived control over events following childbirth (Fahey & Shenassa, 2013), of which postoperative wound healing would be a significant factor.

2. Loss of control over decision-making

Shared decision-making is associated with patient satisfaction and improved outcomes across both obstetric (i.e. Gee & Corry, 2012; Say, Robson, Thomson, 2011) and wound care literature (i.e. Jaensson, Dahlberg & Nilsson, 2019; Borrell-Vega, Humeidan & Bergese, 2018). For the most part, poor CB related outcomes have been linked to loss of control over a meaningful birth event as described above. However, loss of perceived agency over a CB is complex, with some authors proposing that other mediating factors contribute towards variance in findings. For example, due to the emergency nature of unplanned Caesareans, women would have less time to come to terms with the decision to have a CB, and are less likely to be involved in the birthing process, resulting in feelings of lack of ownership over the birth (Coates, Thirukumar & Henry, 2019; Yang & Sun, 2017). Women that have had an unplanned Caesarean are also more likely to have had a general anaesthetic procedure, appertaining to slower recovery and coherence following birth (Bayes, Fenwick, J & Hauck, 2012; Herishanu-Gilutz *et al*, 2009). This has been linked to increased loss of control, dissatisfaction and a sense of lasting disconnection from their infants (Lobel & DeLuca, 2007). On the flip side, for those that planned their Caesareans, loss of agency can be experienced from the onset of antenatal care. For example, Djatmika, Lusher, Meyrick & Byron-Daniels' (2020) review of qualitative studies identified that some women experience frustration at having to defend their CB decision to healthcare professionals who are largely pro vaginal birth

3. Loss of control over one's body

Research participants that have undergone both planned and unplanned Caesarean procedures can also report loss of control in clinically led surgical environments, as illustrated by qualitative research themes such as ‘in your hands’ and ‘scared to death’ (Puia, 2013). These findings demonstrate how loss of control in medical situations can elicit different emotional responses contingent on a complex combination of factors, such as degree of pre-surgical preparation and trust in healthcare staff (Tomsis *et al*, 2021; Burcher *et al*, 2016).

Furthermore, evidence from existing wound studies suggest that post-surgical complications (i.e. hard-to-heal wound) can compound feelings of loss of agency over bodily boundaries and medical decision-making (i.e. Monsen, Acosta. & Kumlien, 2017; Andersson *et al*, 2010). This could have significant connotations for women living with problematic post-Caesarean wounds who are already burdened by perceptions of loss of control over a meaningful event, birth decision-making and bodily ownership.

1.2.5.2 Patient-centred communication

The concept of ‘empathic care’ relates to the acknowledgement and validation of patients as individuals with subjective needs, attributes and perspectives (Pereira, Figueiredo-Braga & Carvalho, 2016). ‘Patient centred communication’ relates to a way of engaging with patients that conveys empathy and puts the patient at the centre of their return to wellness (Naughton, 2018; International Best Practice Statement, 2016). These philosophies are a move away from the biomedical approach, which stipulate healthcare professionals as the voice of authority. Under this model, healthy pregnant women are traditionally labelled as ‘patients’ that require medical intervention and direction over medical decision-making in a clinical setting (Johanson, Newburn & Macfarlane, 2002).

Findings from wound care and postpartum studies alike highlight how patient-centred care models, that promote a sense of agency and forge shared decision-making, can improve patient outcomes (Nieuwenhuijze & Leahy-Warren, 2019; Lindsay *et al*, 2017). For example, studies involving generic postoperative patients postulate that being treated with ‘*respect and dignity*’ (Jaensson, Dahlberg & Nilsson, 2019) and having a ‘*sense of trust in healthcare providers*’ predicted patient satisfaction and post-surgical health (Jones *et al*, 2017). Similarly, in maternity care literature, the term ‘with woman’ is synonymous with a patient centred philosophy and is likewise associated with maternal agency and self-efficacy (Royal College of Midwives, 2022). Though seemingly minor, there is overwhelming evidence that positive moment-to-moment interactions with healthcare staff during the intrapartum can significantly impact maternal adjustment, for example by buffering against post-traumatic stress disorder (PTSD, Ayers, Radoš & Balouch, 2015) and by promoting maternal confidence and quality bonding with the infant (Upton & Upton, 2015).

Furthermore, research surrounding patient centred communication also encapsulates fulfilment of informational needs, with emphasis on appropriateness and quality of information provided by healthcare agencies (Royal College of Obstetricians & Gynaecologists, 2022). Again, there are parallels across generic outpatients and postnatal study findings. For example, those that experience unexpected side-effects, whether during or after the surgical intervention, or are given conflicting advice, report a sense of helplessness and loss of confidence in medical staff responsible for their care (i.e. McLeish, Harvey, Redshaw & Alderdice, 2021). Qualitative studies illuminate women’s experiences of feeling ‘*frightened*’ (Coates, Thirukumar & Henry, 2019) and

‘*disempowered*’ (Puia, 2013) when faced with unexpected postpartum symptoms (i.e. persistent pain) and complications (i.e. dehiscence) associated with CB site wounds. It is argued that this stems from antenatal preparations that largely focus on biomedical and systematic areas of birth (i.e. breastfeeding) as opposed to the psychosocial dominions that hallmark the postnatal period (i.e. ability to provide care; Baghirzada, Ibrahimov, Macarthur, 2018; Slomian *et al,* 2017.;Martin, Horowitz & Bulbierz, 2014). Furthermore, findings stipulate that antenatal education packages traditionally cater for ‘natural’ (vaginal) births, further marginalising women who have given birth surgically (Djatmika, Lusher, Meyrick & Byron-Daniels, 2021). In this regard, there is evidence that stigma attached to a medical condition, or lack of trust in care providers, can negatively impact help-seeking behaviour and early intervention in diagnosing and preventing further wound morbidity (Lusher, 2020).

1.2.5.3 Maternal transition theories

The year following birth is recognised as an important transitional event for new mothers and their family unit (Shaw, Levitt, Wong & Kaczorowsk, 2006). The theory of maternal identity formation via role fulfilment stems back to the 1960’s and is based on nurses’ observations that maladjustment occurs when a new mother’s self-concept, or perception of her abilities, is misaligned with pre-conceived expectations of motherhood (Rubin, 1967).

On this note, Mercer’s (2004) theories of maternal adjustment advocate that role attainment, such as establishment of family boundaries, is provisional on physical recuperation during the early postpartum. Mercer further stipulates that a new mother’s status is heavily determined by body image (or perceived physical ability to perform set roles), with loss of bodily capacity linked to feelings of loss of agency, guilt and low self-esteem.

This theory could explain why post-Caesarean mothers frequently report feeling that they have ‘failed’ and experience a sense of disconnection from their infants. For example, studies illustrate how for some women the Caesarean procedure can be seen as an aberration of what a ‘normal’ birth should entail (i.e. as a symbolic gateway into motherhood) leading to a decreased sense of self and disrupted mother-infant attachment (Benton *et al*, 2019; Kjerulff & Brubaker, 2017; Puia, 2013; Lobel & DeLuca, 2007). Furthermore, compared to counterparts who deliver vaginally, women who give birth via Caesarean can mobilise less quickly and have later initial contact with their infants; a potential disadvantage given that the immediate period after birth is often described as the ‘golden hour’ that sets the precedence for maternal-infant bond forging (Butler, 2020).

Additionally, a review of articles surrounding maternal social domains published between 2003 and 2013 concluded that terminology surrounding biopsychosocial approaches in maternal health overlapped and lacked progression in the decade being investigated. Nevertheless, three key themes were identified from the findings: successful ‘*transition to maternal role’* as contingent on maternal self-efficacy, defined as the degree of confidence or self-belief a new mother has in her ability in controlling and achieving expected maternal roles. The second theme ‘*maternal role and function’* relates to identity reconfiguration as being contingent on women’s physical ability in providing caring responsibilities, while the third theme ‘*psychosocial and social support’* relates to external influences (Suplee *et al*, 2014).

In summary, existing qualitative investigations support the underlying theory that maternal self-efficacy is tied to internalisation and conformity to 'good mothering' ideologies, otherwise known as 'intensive mothering', relating to organic, child-centric parenting style (Sonnenburg & Miller, 2021). It can thus be rationalised that delayed CB wound healing and the associated interferences on ability to fulfil expected roles, will have a more profound impact on women who are already struggling to accept their unwanted CB births.

To this end, the impact of complex healing on identity formation is widely recognised in wound studies; for instance, analysis of narratives of military personnel with hard-to-heal amputation wounds indicate that delays in their repatriation back to civilisation due to slow recovery can disrupt their sense of psychological transitioning (Neal, 2015). These findings could hold merit for the current research population, wherein there is a clear distinction between self-identity before and after surgical wound attainment (becoming a new mother), and delayed recovery would arguably have significant psychosocial repercussions on identity adaption. This further highlights the need for qualitative research methods as a way of accessing abstract concepts, such as recovery, that are difficult to define via quantitative means (Sultan *et al*, 2020).

1.2.6 Summary of literature- what do we know about the biopsychosocial impact of Caesareans?

Though currently debated, there is an over-riding agreement within the limited evidence base that women who have given birth via Caesarean can be less satisfied with their births compared to those that have had vaginal births, and can evaluate themselves and their infants less positively (Karlström, Lindgren & Hildingsson, 2013., Miesnik & Reale, 2007).This debate is fuelled by the reliance on global findings and lack of methodologically robust studies (Sandall *et al*, 2018). Regarding the latter, one prevailing criticism of Caesarean outcome studies is the combination of planned and unplanned Caesarean samples in study analyses (Leow, Tan & Black, 2021; Lobel and DeLuca, 2007). However, some authors argue that this dual classification system is unsound, and an over-simplification of women's complex decision-making process (Tully & Ball, 2013; Fenwick, Holloway & Alexander, 2009). On this note, NICE (2013) states that it is women's individual preconceptions and expectations that will ultimately influence how women feel about their Caesarean births and recovery.

Despite their increase in popularity, Caesareans are still major abdominal surgery resulting in medical contingencies that vary according to clinical and non-clinical patient indices (The Scottish Government, 2021; Childs *et al*, 2020). To this end, qualitative studies on post-operative patients reveal how wounds resulting from surgery or injury carry subjective psychosocial connotations (i.e. Pađen, Griffiths & Cullum, 2022; McCaughan *et al*, 2018; Neal, 2015). Living with a wound that is failing to heal within the anticipated time scale can be a life changing occurrence (i.e. Pinto *et al*, 2016). There is sufficient evidence in literature to indicate that postpartum recovery complications can disrupt symbolic gateways into idiographic motherhood identities. Yet, there is a clear neglect in research of how the coalescence of the major life events of surgical birth, living with a complex wound and mothering an infant impacts on women and their families.

On this note, health psychology approaches in wound healing can offer further explanation on the link between ongoing postpartum physical morbidity and psychopathology. This will be explored further in the next part of the chapter.

1.3 Caesarean wound healing- a health psychology perspective

The increasing global burden associated with wound management has been highlighted as a concern. In the UK for example, the annual prevalence of wound care increased by 71% in just 5 years between 2012/12 and 2017/18. The annual cost of wound care in 2017/18 was £8.3 billion, of which more than 60% of this cost was spent on treating hard-to-heal wounds (Guest, Fuller, & Vowden, 2020), suggesting a need for reformed strategies surrounding cost-effective patient care interventions.

Consequently, traditional health psychology theories and frameworks such as Leventhal et al's Self-Regulatory Model or Common Sense Model (1996;1997) has been adapted to explicate wound related outcomes by positing that recovery is impingent on health beliefs and illness cognitions such as self-identity and perceived control over healing. For example, findings from postsurgical dental (McCarthy *et al*, 2003), elective abdominal, vascular, thoracic surgery (Paddison *et al*, 2009) and colorectal cancer surgical patients (Johansson, Brink, Cliffordson & Axelsson, 2018) corresponded to the 5 key constructs of Self Regulatory Model. These 5 domains are: identity (how one defines illness based on somatic symptoms and labelling), cause , timeline (expectations regarding duration of illness), cure/control (beliefs about treatment or personal ability to cure or control illness) and consequences (perceived impact of illness on daily function and roles). Of note, these studies conclude that mental representations associated with preoperative expectations strongly mediate recovery outcomes such as wound healing.

Recently, health psychologists call for a holistic biopsychosocial approach in wound care, arguing that the person living with the wound is often taken out of the equation in discourses surrounding wound management (Lusher, 2020; Lusher *et al*, 2020). For example, Cullum *et al* (2016) highlight that patient participation is noticeably absent from the European Wound Management Association (EWMA) work in designing frameworks guiding patient related outcomes. Additionally, the relationship-care model at the heart of the biopsychosocial model postulates that the person living with the condition is not a passive recipient of medical authority (Borrell-Carrió, Suchman & Epstein, 2004). In line with this, psychoneuroimmunology can offer a better understanding of the link between biopsychosocial factors and surgical wound healing; namely negative affect such as pre-surgical stress disrupts healing via two interconnected pathways: activation of neuroendocrines which delay healing by interrupting inflammatory and immune responses, and by triggering unhelpful coping mechanisms such as smoking and avoidance type behaviours. Adapting to wound related domains, such as changes to body image and mobility in itself is a stressor, meaning the person living with the wound can be perpetually caught in a negative stress-neuroendocrine response cycle contributing to chronicity or slow-healing of the wound (Basu, Goswami, David& Mudge, 2022; Powell *et al,* 2016; Broadbent & Koschwanez, 2012; Mavros *et al*, 2011).

The association between negative affect and healing is well established; a widely cited systematic review and meta-analysis indicates a strong negative relationship between wound healing and stress across both experimental and observational studies (Walburn *et al,* 2009). Furthermore, two separate systematic reviews investigating psychosocial influences on surgical outcomes found

that pre and inter surgical attitudes (i.e. coping strategies) and mood could predict clinical results, even after controlling for predisposing factors (Mavros *et al*, 2011; Rosenberg *et al*, 2006).

Despite the long standing robust evidence linking psychosocial factors to wound healing outcomes, it is only recently that advances in wound care management have recognised the merit of adopting biopsychosocial elements. For example, the wound assessment tool known under the acronym of TIME (Tissue, Infection/ Inflammation, Moisture balance, wound Edge) has lately been updated to TIMERS to include tissue regeneration (Repair) and patient social factor domains (Social; Atkin e*t al*, 2019). Similarly, the UK National Wound Care Strategy Programme (2021) recommends a structured approach to pre-surgical assessment encompassing patient psychological/ social and cultural/ ethnic factors.

It is worth noting however that the samples included in these quantitative studies are largely heterogeneous and lacking in statistical power (Britteon, Cullum & Sutton, 2017), meaning care must be taken in generalising the findings to other populations such as the maternity cohort. Furthermore, the authors found that wound complications in anxious or depressed patients was related to re-admissions following hospital discharge. Taken together, these findings highlight the need for further investigations into the mechanisms of emotive responses in wound healing, of which pain is a distinguishing factor. This will be further discussed further in the sections below, firstly considerations surrounding wound healing terminology is merited.

1.3.1 What is a slow-to-heal wound?

Surgical wounds are usually defined as acute, meaning the surgical wound heals by primary intention (wound cavity medically closed) within an expected timeframe. For a variety of reasons including modifiable behaviours (i.e. smoking, non-adherence to medication) and patient factors (i.e. age, underlying comorbidities), a wound can fail to heal within the projected timescale; this type of wound becomes defined in literature as a 'chronic' or 'hard-to-heal' wound (Milne, Searle & Styche, 2020; Bullough, 2016; 2014). One challenge faced by health professionals and researchers lies in measuring the impact of delayed wound healing, due to the lack of consensus regarding the definition and timescales of what constitutes delayed healing (Childs *et al*, 2020; Vowden, 2011; Soon & Acton, 2006; Salcido, 2005). In their commentary piece, Webb (2019) observes that terminologies such as 'chronic', 'hard-to-heal', 'slow-to-heal' and 'non-healing' are used interchangeably in wound care literature. Though they note that the terms 'chronic' and 'non-healing' are synonymous with wounds associated with advanced conditions such as diabetic and venous foot ulcers, or complex fungating wounds. The time the wound takes to close and appearance of the wound within certain timeframes are also popular measures used by clinicians to predict and identify abnormal healing (Murphy *et al*, 2020; Masson-Meyers *et al*, 2020; Milne, Searle & Styche, 2020; Upton & Upton, 2015; Vowden, 2011). However, these recommended guidelines have been described as uninformed and lacking in clinical empiricism (Webb, 2019; White, 2011). For example, a systematic review reported that studies cite between four to six weeks as the standard for full wound closure or healing following surgery (Ireton, Unger, Rohrich, 2013). Whilst other sources define hard-to-heal wounds as wounds that have not healed by 40%-50% following four weeks of standard clinical care (Atkin *et al*, 2019). Salcido (2005) reasons that closure of the acute wound does not necessarily indicate a return to 'normal' functioning, and further argues for healing endpoints to be determined by the patient living with the wound as per their subjective experiences and expectations.

Additionally, wound healing is a visceral experience. In this sense, wound healing markers are arguably not only observed visually as recognised by clinical guidelines, but also involves the complexities of feeling and experiencing sensations such as pain (Matsuzaki & Upton, 2013). In this regard, there is also a lack of agreement regarding what constitutes persistent wound pain. Measurements of persistent pain vary in literature from a few weeks to a few months post-surgery (Milne, Searle, & Styche, 2020; Richardson, 2012). Moreover, self-report of frequency of pain sensations within a certain time period have also been used as clinical scoring systems in studies (Jin *et al*, 2016). Advancements in pain management are likewise moving towards patient centred care wherein treatment is guided by patient outcomes as opposed to arbitrary timelines (Lusher, 2020; Lusher *et al*, 2020; Woo, 2012).

To this end, this study will use the terms 'hard-to-heal', 'slow-to-heal' and 'complex' wounds to describe post Caesarean wounds that have taken longer to heal than anticipated by the person with the lived experience.

1.3.2 Pain and wound healing following Caesarean births

Pain has been defined by the International Association for the Study of Pain as '*an unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage'* (IASP, 2020). This definition was only recently revised since the late 1970's to include biopsychosocial considerations, such as recognition of pain as a subjective experience, and to some extent behaviour that is learnt in response to biological, cognitive and social influences (Ghoshal, 2022; IASP, 2020).

In this sense, the unique role of pain in childbirth can be explained within cultural and social contexts, in that the experience of pain during childbirth (or lack thereof) has significant meaning to some women in the transition to motherhood. For example, some women birthing by Caesarean feel cheated and ashamed that they did not experience labour. This feeling of guilt can become exacerbated when new mothers are not able to fulfil maternal related roles due to post Caesarean pain (Larkin, Begley & Devane, 2009; Moore, 2004). On another note, the medicalisation of normal physiological pain caused by pregnancy and childbirth has meant that for some women, childbirth pain is highly undesirable or even seen as a significant threat (Murphy & Strong, 2018; Johanson, Newburn, Macfarlane, 2002).

Pain is intrinsically linked to wound healing; most post-operative patients define successful recovery as a return to baseline state and daily activity, of which pain is a determining factor (Wisner, 2022; Hopkins, 2001). Consequently, more attention has been paid to investigating the risk factors, prevalence, duration and impact of pain following surgical births considering the increase in global prevalence. In these studies, survey data is captured at various intervals before and after the Caesarean procedure (i.e. Mehrnush, Imani, Shirdel & Rabie, 2020). A meta-analysis of sound RCT studies found that 11% of women still report pain 12 months post Caesarean birth (Komatsu, Ando & Flood, 2020). However, it is worth noting that the prevalence of persistent pain attributable to the impact of Caesarean surgery itself (and not i.e. pre-existing pregnancy health issues necessitating surgery) is still under debate (Eisenach, 2013). Lack of a standardised approach in how self-reported pain is measured means that caution must be taken in comparing results. For example, Komatsu, Ando and Flood (2020) suggests that pain at the incision site is more likely to be reported as persistent. However, symptoms participants report fit descriptions for dysaesthesia type sensations due to scar hyperalgesia, which is not recognised within the

clinical definition of persistent pain and not indicative of abnormal wound healing (Vader *et al*, 2021), but is nevertheless reported as having an impact on quality of life (Komatsu, Ando & Flood, 2020). Additionally, a meta-analysis of thirty-eight articles on chronic post Caesarean pain identified chronic pain attributable to the wound site as opposed to other areas (i.e. back) as a primary finding. According to this review, prevalence of wound site pain ranged from 15.4% at 3 to 6 months to 11.2% at 12 months or longer, with at least 9% reporting the pain as severe at 12 months. These variance in findings highlight the need for further understanding of how new mothers live with and experience post Caesarean pain in the context of delayed wound healing.

1.3.3 Connecting the biopsychosocial experience of Caesarean birth and delayed wound healing

Overall, studies illustrate the importance of early preparation for all expecting women regardless of mode of birth choice (Wisner, 2022; Howell, Mora, Chassin & Leventhal, 2010). Pre-surgical factors such as anxiety over the birth procedure, and intensity of acute post Caesarean pain are empirically linked to persistent pain, which in turn pertains to slower recovery and disordered mood (Chen *et al*, 2021). It is well established that ongoing pain disrupts sleep, alters hormone functions and behaviour; parameters that are evidenced to impact healing in the generic population (Powell *et al*, 2016; Mavros *et al*, 2011). Yet, not much is known regarding how persistent post Caesarean wound issues such as ongoing surgical site pain compounds or complicates these factors that are already significantly altered in the postnatal population.

Paradoxically, despite evidence that some women opt for Caesareans due to anxiety over childbirth, findings suggests that on the contrary, recovery from a Caesarean involves more intense acute post-operative pain that carries on for a longer duration compared to spontaneous birth (Sys *et al*, 2021; Karlström *et al*, 2007; Wiklund, Edman & Andolf, 2027). Some authors argue that the Caesarean procedure in itself is a risk factor for persistent pain. For example, Niklasson *et al* (2015) found that duration of the Caesarean procedure correlated with persistent pain in a linear fashion. Their explanation is that complicated surgery would have physical repercussions, meaning the body will naturally take longer to heal. However, other aspects worth considering are psychological factors such as fear and divergence in birth expectations that are also proven to impact pain perceptions (Saxbe, 2017; Jin *et al*, 2016), which in turn can disrupt the neuroimmunological mechanisms responsible for wound healing. On another note, pregnant women that identify as having a fear of childbirth are also found to have a lower pain threshold in general (Saisto & Halmesmäki, 2003), are more likely to catastrophise (Olsson, Buer, Holm & Nilsson-Wikmar, 2009; Saisto, Kaaja, Ylikorkala & Halmesmäki, 2001), and are more likely to undergo a Caesarean procedure (Dehghani, Sharpe & Khatibi, 2014; Saisto & Halmesmäki, 2003).

Though traditionally applied to studies surrounding health behaviours and chronic conditions, one study demonstrates how health psychology models such as the Health Belief Model and Self-Regulatory Model can account for up to 39% of postnatal variance related to physical and emotional health (Jessop, Craig, Ayers, 2014). Essentially, higher levels of self-efficacy, or a person's belief in their ability to successfully control pregnancy outcomes predicts better postnatal health results. Moreover, lower self-efficacy scores in pregnancy is associated with greater fear of childbirth related pain and likelihood of requesting a Caesarean (Hassanzei, Navidian & Navaee, 2022., Dadipoor *et al*, 2018).

Despite this, it is still unclear how to best support these women that are more likely to be vulnerable to the impact of worsened post-Caesarean wound morbidity. Patient centred, qualitative approaches are suggested to gain better understanding of the relationship between psychosocial domains of surgical birth such as fear and pain (Stilwell & Harman, 2019; Lockerbie & Turin, 2018; Salcido, 2014), how this reciprocates with poor post Caesarean wound healing, and what this means in real life terms for the women living with these wounds.

1.4 Study overview and rationale

CB rates in the UK have surpassed the 15% cut-off rate advocated by the World Health Organisation, suggesting an unacceptable proportion of unnecessary surgery that poses a risk to maternal health (Betrán et al, 2016). Moreover, risk factors associated with poor CB outcomes are also on the rise in the UK, this includes underlying medical comorbidities such as obesity and diabetes as well as non-modifiable risk factors (Słabuszewska-Jóźwiak, Szymański, Jóźwiak & Sarecka-Hujar, 2021; Essex, Green, Baston & Pickett, 2013; Wloch et al, 2012). An example of the latter includes maternal country of birth, with the ratio of births to women born outside the UK already increasing by 2.1% between 2015 and 2016 (Office for National Statistics, 2019). CBs are unique in that women are discharged from hospital care with a new-born infant and a post-surgical wound to manage in addition to new-found daily responsibilities (Jolly, 2017). There are similarities across both wound studies and postnatal findings in that these life events are described as all-consuming and having a significant impact on the subject's identity and overall life course. Despite this, there is a clear gap in knowledge, with a notable precipice of research extending past pregnancy and birth, hence postnatal women earning the title '*silent mothers'* in academic literature (Sega, Cozart, Cruz, & Reyes-Foster, 2021).

In this regards, existing studies illustrate how perceptions of loss of control before or during surgery extends to the recovery period when there is a continuation of feelings of lack of ownership over what is happening to one's body (i.e. pro-longed wound healing; Pinto et al, 2016). This is pertinent, as stress/ trauma can disrupt protective biochemical responses (i.e. immune system) responsible for healing (Brown, 2016; Upton & Solowiej, 2010; Walburn *et al,* 2009; Lutgendorf & Costanzo, 2003). The vicious circle of chronic pain, mood disturbances and maladaptive behaviours (i.e. movement avoidance) associated with atypical healing further impedes natural healing mechanisms and overall mental well-being (Walburn et al, 2017; Alexander, 2013; Flink *et al*, 2009). For example, CB surgical site pain is a risk factor for non or reduced breastfeeding (Karlström et al, 2007), despite the release of oxytocin during breastfeeding which is a hormone that can boost postpartum recovery (Quinlan, 2019; Komatsu, Carvalho & Flood, 2018). In recent studies, qualitative methodologies have been advocated as a way of capturing and understanding the psychosocial experience of the person living with the wound (i.e. McCaughan *et al*, 2018; Salcido, 2014).

This direction is very relevant in postpartum care; meta-synthesis and systematic reviews of qualitative literature on the subject summarise how women that are recovering from a CB have complex, multidimensional needs that are often subjugated by social expectations and subjective ideologies of what it means to be a mother (Benton et al, 2019; Lobel & DeLuca, 2007). Despite the known healthcare cost burden and implications associated with poor obstetric outcomes (i.e. impaired lacto production; Tatano & Watson, 2008), there is an absence of published research

that aims to explore and examine the perspectives and attitudes of women who are experiencing complications with CB wound site healing. This is worth investigating, as qualitative research exploring generic outpatients' experience of poor postoperative wound healing reveal that this cohort present with unique challenges and needs that may not be recognised by generic care regimes (McCaughan et al, 2018; Tanner et al, 2012).

In this regard, this study aspires to employ qualitative research methodology underpinned by a feminist lens. This philosophy is particularly suited to research that aims to investigate deeply entrenched gendered practices that are imbued in socio-political "double-talk" (Yuill *et al*, 2022, p.7). An example of this is the feminist critique of the "illusion of choice" of CBs, whereby the reality of birth choice is in fact driven by wider patriarchal agendas of medicalising women's reproductive bodies (Crossley, 2007). The focal point of feminist inspired qualitative research is the rejection of women as research subjects and biomedical participants, but rather involving women as experts and owners of their own lived experiences in a way that is 'woman-centred and empowering' (Moyzakitis, 2004, p.9).

Overall, there is a lack of awareness regarding the real-life connotations of surgical birth layered with the biopsychosocial impediments of recuperating with a slow-to-heal wound while caregiving. Postnatal health is an important area demanding further attention considering that a higher proportion of postnatal women report suicidal thoughts in comparison to the general population estimates. The percentage of lifelong prevalence of suicidal ideation in postnatal women compared to the general population is 18.3% and 10.6% respectively (Liu, Bettis & Burke, 2020; Sega, Cozart, Cruz & Reyes-Foster, 2021).

These findings illustrate the need for further research into women's experiences of living with a slow-to-heal CB wound, as a way of scrutinising national policy and guidance relating to patient-centred postnatal discharge packages. Increased understanding of women's needs can arguably not only inform betterment of support that is already available for women with slow-to-heal CB wounds, but also prevent morbidity via enhanced antenatal care.

With this in mind, this study aims to explore the experiences of women recovering with slow-to-heal Caesarean wounds. More specifically, the objectives of this study are to:

- Gain in-depth understanding of the emotional and psychosocial experiences of women who are living with slow-healing CB wounds.
- Identify challenges women face in managing slow to heal CB wounds while navigating motherhood; markers which may have a permanent impact on mother-infant health and wellbeing.
- Inform further research which may promote further consideration of suitability and economical design of current perinatal care packages.

To the researchers' knowledge, this is the first study to investigate the lived experience of women coping with a delayed CB surgical wound using a qualitative approach.

2 Methodology

This chapter discusses the rationale for using a qualitative approach, and more specifically using Interpretative Phenomenological Analysis (IPA) to answer the research question. In the interest of promoting coherence and trustworthiness, it also aims to detail how the research was conducted. Readers will note that discourse in this section will be move from an academic stance, observed in the rest of the research thesis, to a more personalised and reflective writing style. This sits within IPA positioning of the researcher as inseparable from the analytical process, wherein the researcher leaves ‘footprints’ of their own views, attitudes and presuppositions that should be as transparent as possible to the reader (Smith, Flowers & Larkin, 2012). In this regard, a section of reflexivity will close this chapter as I attempt to make more transparent my influence and orientation within the research.

2.1 Rationale for using a qualitative study design

Patient care treatment and guidelines have largely been guided by positivist approaches in research (Charlick, Pincombe, McKellar & Fielder, 2016; Burgess-Proctor, 2015; Gough & Deatrick, 2015). More recently, there has been a call for qualitative research that delves beneath the surface of statistics and figures to gain a more meaningful perspective of what findings mean for those living with the topic being investigated (Lockerbie & Turin, 2018; Charlick, Pincombe, McKellar & Fielder, 2016; James, 2015; Gough & Deatrick, 2015). Similarly, authors such as Snow (2009) argue that it is paradoxical to capture subjective paradigms such as recovery and pain, using quantitative tools that are designed to develop generalisable knowledge or theories.

In literature, there is a clear division between quantitative methods driven by ‘*predictability and control*’ as patriarchal and qualitative methods that aim to ‘*describe and understand*’ experiences that are categorised as falling within feminist realms, and are therefore suited to women’s dominions such as childbirth (Rogers, 2008, p. 179). On a more figurative note, qualitative research that focuses on embodiment and giving voice to those being researched has the potential to reduce and flatten hierarchical imbalances that are already prevalent in maternity care and research (Hansen, 2019). This could be of value to postnatal women and their families who are described in literature as ‘silenced’ (see section 1.2.4).

Overall, the emerging qualitative paradigm in maternity-related research complements and can allow empathic insight for practitioners working towards the NHS (2012) commitment in offering personalised, woman-centred care.

2.1.1 Interpretative Phenomenological Analysis

This study assumes a critical realist position which posits that knowledge is embedded and contained within our subjective socio-cultural world. In this regard, the researcher is concerned with making sense of a particular phenomenon with the understanding that multiple ‘realities’ exists. The goal is not to generate universal truths about how variables interact and inter-relate in order to explain a phenomena, but rather to offer a nuanced understanding of the phenomena under investigation (Peat, Rodriguez & Smith, 2019; Pietkiewicz & Smith, 2012; Smith, Flowers & Larkin, 2012).

More specifically, this study uses Interpretative Phenomenological Analysis (IPA) in order to answer the research question, ‘ how do women who have had a CB experience delayed surgical

wound healing, and what is it like to live with these wounds?'. In order to certify the epistemological and ontological fit between IPA and the research question, it is first imperative to comprehend the philosophical underpinnings of IPA.

IPA stems from the Husserlian tradition of phenomenology, appertaining to the study of lived experience. Under this philosophy, the role of the researcher sits in objectively harvesting the 'essence' of experiences that are construed within participants' accounts. IPA is also underpinned by Heideggerian hermeneutics in that IPA seeks to explore how the participant reflects on the study topic, as interpreted by the investigator equipped with their own pre-suppositions (Roberts, 2013; Smith, Flowers & Larkin, 2012; Thomson, Dykes, & Downe, 2011; Norlyk & Harder, 2010). Hence, 'multiple hermeneutics' occurs as the researcher has a double role in attempting to see the world from the participant's perspective, while also critically engaging with the participant's narrative to offer an in-depth translation or to '*read between the lines'* of what the participant is trying to say (Shinebourne, 2011, p.6).

Finally, IPA is idiographic in that this approach is committed to the particular and how individuals construe experience. In this regards, similarities and differences across individual cases are interwoven, but the focus remains on depth of findings as opposed to breadth. Therefore, IPA involves a process of continual interaction between the researcher and dataset, the end product being a reader's individualised attempt at understanding the narrative as illuminated by the researcher (Shinebourne, 2011; Biggerstaff & Thompson, 2008; Mapp, 2008).

The discourse surrounding phenomenological research in nursing literature is largely divided into two scholarships: 'descriptive phenomenology' of the Husserlian philosophy and 'hermeneutics' or 'interpretative phenomenology' as stemming from Heideggerian teachings (Norlyk & Harder, 2010). For many nursing academics, descriptive phenomenology is attractive for a number of reasons including the benefit of an empirical set of guidelines designed to capture 'morphological' essences of experience that are situated within specific points of time (Giorgi, 2012). The concept of 'bracketing' in descriptive phenomenology is also alluring for naïve researchers as pre-existing knowledge on the subject matter in not necessitated, and is even seen to pollute the essence of participants' narratives (Roberts, 2013). Though I am not from a nursing background and have limited awareness regarding Caesarean wound healing prior to this study, I stand in agreement with Mapp (2008) in that it would be impossible and perhaps even objectionable to erase the researcher's footprints from the inquiry process. Callister (2004) states that '*when stories are not only described but interpreted by researchers, they gain clinical applicability*' (p.514). To this end, I believe that IPA is aligned with feminist notions of empowering women through research, by acknowledging women as active agents involved in wider oppressive systems, as opposed to passive subjects (Callister, 2004)

I also believe that IPA being rooted in all three philosophies of descriptive phenomenology, interpretative phenomenology/ hermeneutics and idiography is another benefit. I felt that the ability to produce new knowledge that is derived from the experiences of participants as 'lived experts' while still honouring rigour and empiricism in research was a significant feature.

Furthermore, I also believe the symbolic-interactionism tenets of IPA concurs with the lived experience of new mothers and wound healing patients that are situated within cultural, social and systemic interactions.

'Plan Z and then off the edge of a cliff': an interpretative phenomenological analysis of mothers' experience of living with a slow-to-heal Caesarean wound.

Below I will provide further detail regarding my rationale for using IPA to answer my research question.

2.1.2 Rationale for using IPA

As highlighted above, this study employed a qualitative method using IPA to allow deeper insight into the idiosyncratic experience of living with a slow-healing postpartum Caesarean wound. The theoretical underpinnings of IPA dovetail with the study's aim of aligning with the person-centred approach advocated by current wound studies. An example of the later is the Bluebelle Study Group (2017), that aims to inform postsurgical patient outcome measures by integrating qualitative patient outputs. Moreover, the IPA Heideggerian positioning means this method is particularly suitable for studies that are dedicated to investigating how socio-cognitive accounts of bodily experiences are construed within language and text (Hefferon & Gill-Rodriguez, 2011).

More recently, the phenomenological scholarship has been expanded towards clinical advancements in understanding pain and shaping intervention. As an example, enactive models of pain advocate that pain is embedded, embodied and enacted within the context of one's own sociocultural lens (Stilwel & Harman, 2019): this marries with the very spirit of IPA. 'Birth stories' as the way women make sense of and allocate meaning to their birth experience via shared narratives also fits within the concept of 'Gerede' or 'Idle Talk' in hermeneutic scholarship. 'Idle Talk' has been described as '*the way of speaking within our shared world*' which contributes to how new knowledge is formed and integrated culturally (Kay, Downe, Thomson, & Finlayson, 2017, p.4). Parratt and Fahy (2011) have argued that the theoretical underpinnings of the Transition to Motherhood theory in itself is limited within positivist and logico-empirical constraints, meaning there is an assumption that a singular logic can be used to explain and predict outcomes in all new mothers. The authors argue that this philosophy compounds a reductionist view of women, in that all new mothers are internally programmed to achieve 'good mothering' ideologies and standards. This simplistic logic underlies the rationale for explaining maternal postnatal adjustment. Instead, it is proposed that an approach such as IPA would be more suited in capturing the dynamic and varied phenomenon of identity transition that symbolises the postpartum stage. Indeed, IPA has vastly contributed towards understanding the complexities of motherhood, examples include new mothers' decisions to continue breastfeeding (i.e. Spencer, Greatrex-White & Fraser, 2015), and the perceptions and challenges faced by new mothers, or mothers- to- be with complex needs, such as those with eating disorders (i.e. Chinello *et al*, 2019) and chronic illnesses (i.e. Facchin *et al*, 2021). As a health psychologist in training working in a public health team, the IPA scholarship also appeals to my personal doctrine of working holistically to understand behaviour or facilitate behaviour change goals. Naturally, I have considered other methodologies that could best tackle my research aims. Grounded Theory and Thematic analysis were the two main qualitative research methods I deliberated on.

2.1.2.1 Grounded Theory

First coined by sociologists Glaser and Strauss (1967), the aim of this qualitative method is to generate theory from findings that are 'grounded' in narratives and other similar qualitative data. Grounded theory would be suited to exploring phenomena that are distinguished by social processes such as postpartum recovery, and for this reason is popular within nursing and

maternity research. For example, Fenwick, Holloway and Alexander (2009) used the grounded theory approach to explore multipara mothers' reasons for having a repeat CB and their experiences of this procedure. Similar to IPA, an iterative 'line by line' approach is used to elicit themes or codes from the dataset. However, whilst IPA is committed to the deeper understanding of concepts, the aim of grounded theory is to develop theoretical understanding derived from emerging categories or themes (O'Gorman *et al*, 2013; Willig, 2012; Starks & Trinidad, 2007; Braun & Clarke, 2006). In the case of Fenwick *et al's* (2009) paper, the key theme '*achieving normality'* following a CB was identified as the theoretical basis for the purpose of informing clinical practice and strategies. However, for the purpose of this study, I felt that the IPA approach was more concomitant with the research purpose of understanding lived experience on a granular level as opposed to engendering theory.

2.1.2.2 Thematic analysis

The aim of thematic analysis is to identify patterns or themes across qualitative datasets in order to gain an understanding of the phenomenon being researched (Kiger & Varpio, 2020; Braun & Clarke, 2006; Joffe & Yardley, 2004). As such, thematic analysis could be suitably applied to novel areas of research such as the current study. An example of the application of thematic analysis in maternity research is Tully and Ball's study (2013). Similar to Fenwick *et al's* (2009) research, this study involved using in-depth interviews to explore women's experiences of CBs. Using thematic content analysis, this study illustrated how women's context for having Caesarean procedures did not reflect clinical labels such as 'emergency' or 'elective'. In this instance I decided thematic analysis would be less suited for research, such as the current, that recognises birth and wound healing as embedded within individual sociocultural spheres which can only be understood via inter-personal interpretation.

It should be noted that a strength of thematic analysis and grounded theory is the theoretical fit with other methods of data collection such as 'blogs' or 'posts' that are readily available from public sources (Lai & To, 2015; Wilson, Kenny & Dickson-Swift, 2015). Antoniak, Mimno and Levy (2019) wrote that online forums such as Reddit enabled open access to more than 2,000 birth stories containing early postnatal experiences. This could be an alternative solution to recruiting participants, which is time consuming and resource heavy.

Of course, though important and worthy of consideration, pragmatics should not be the most prominent reason for choosing a methodology. Instead, choice of methodology should first and foremost be guided by the research question's ontological and epistemological foundation (Smith, Flowers & Larkin, 2012). In this regard, I believe that IPA is most suited to the current research study that positions postnatal adjustment and surgical recovery as idiographic concepts that are bound by how the person living with the condition makes sense of and explains their lived world to others.

2.2 Patient and Public Involvement

This study incorporated a Patient and Public Involvement (PPI) advisory panel, including two women who had identified as experiencing delayed Caesarean wound healing following an unplanned Caesarean procedure, and two clinicians -a General Practitioner (GP) and a midwife.

The role of PPI in ensuring the research design is robust and accessible to the study population is well recognised in literature (Jackson *et al*, 2020; Jewell *et al*, 2019). The research PPI group for the current study contributed towards shaping the study by informing the participant eligibility criteria, advising on data collection, appraising ethical briefing/debriefing materials such as the participant information sheet/ consent form, and suitability of the interview schedule/ recruitment material (please see appendix 1,p.93, for PPI feedback matrix). Though I followed recommended toolkits (i.e. Involve, 2021; National Institute for Health Research, 2019), I came across challenges in engaging and sustaining PPI throughout the lifecycle of the study. My reflections on engaging with PPI for the purpose of this study is attached in appendix 2 (p. 100).

2.3 Study Eligibility criteria

The following inclusion criteria applied to the study: 1) Women over the age of 18 who have given birth to a live infant via emergency/ unplanned Caesarean Section in an NHS facility in the UK; 2) women with a good command of the English language and 3) women who are currently experiencing delayed Caesarean wound healing or have done so in the past 12 months. With regards to the last criterion, there is a lack of clinical guidelines regarding what constitutes the 'normal' healing period for a Caesarean wound. Therefore, the study call included a set of non-prescriptive descriptors (i.e. wound that has not closed after at least 2 weeks) to help potential participants decide if they were suitable for the study.

The inclusion criteria was expanded after approximately five months after recruitment began, in response to low uptake. The renewed eligibility criteria allowed for the inclusion of women who had planned CBs and extended the eligibility period, and were as following: 1) Women who have given birth to a live infant via Caesarean in an NHS facility in the UK; 2) women with a good command of the English language, 3) women who had experienced delayed Caesarean wound healing within the past 24 months. Further Research Ethics Committee approval was not necessary for this amendment as this contingency plan was already approved as part of the original ethics submission.

2.4 Participant recruitment

Consonant with IPA commitment in extrapolating meaning from datasets, I aimed to recruit a small sample consisting of between four and no more than ten interviewees as advocated by Smith, Flowers and Larkin (2012) as a suitable sample for a Doctorate project. In applying my recruitment strategy, I abided by homogeneity considerations in IPA, namely 'interpretative concerns' of the sample and pragmatic reasoning (Pietkiewicz & Smith, 2012, p.363). To this end, I recognise that homogeneity or similarity of lived experience was to some degree compromised when the eligibility criteria was expanded to include women that had planned Caesareans. However, this is not seen as a methodological limitation due to literature findings and PPI feedback that subjective experiences should not be constricted to clinical labels or diagnoses (I.e. Tully & Ball, 2013).

Participants were purposively recruited from two London libraries with a mother and baby programme, online support groups and forums (i.e. Mumsnet), third sector organisations aimed at improving maternal welfare (I.e. MumsAid) and via word of mouth (snowballing method). Recruitment largely commenced online from September 2021 until May 2022, due to Covid-19 infection control considerations. In the case of closed online support groups and third sector

organisations, permission from the relevant gatekeepers (i.e. group admin) was sought in order to advertise the study call on online platforms (see appendix 3, p.101, for study call).

Other authors have commented on the voice of the 'vocal internet minority' in maternal research (Hansen, 2009). However, this was not my experience; out of the 41 third sector organisations I contacted, only 8 agreed to facilitate the study call. The response rate from social media (i.e. Facebook) groups were slightly higher, with 4 out of 7 gatekeepers agreeing to share the study call with their members. Gatekeepers that responded (N=5) cited not being able to support research projects in general (N=3) or that the study was not aligned with their organisational aims (N=2) as reasons for rejection.

Based on this recruitment technique, 14 women expressed interest in participating; 8 having viewed the study call advertised online and 6 having heard about the study via word of mouth. Of these 14 women, 7 met the study inclusion criteria, consented to being interviewed and were included in the final analysis.

Birth story telling is widely integrated within most cultural norms (Munro, Kornelsen & Hutton, 2009); a recent Make Birth Better (2017) campaign call for online birth stories attracted more than 75 entries within the first week (*in* Svanberg, 2019). For this reason, the lack of response to the intensive recruitment efforts was unexpected. The low uptake could be due to the topic under investigation touching on postpartum difficulties and therefore seen as stigmatising. Furthermore, postnatal women have been described as a 'hidden population' due to sudden changes in lifestyle associated with having a baby, meaning these women perhaps lack the time, energy or motivation to participate in lengthy interviews (Carlin *et al*, 2021; Hansen, 2019). New mothers have also been described as being shielded by society (Carlin *et al,* 2021), thus gatekeeper reluctance to support the study could be due to 'research fatigue' caused by the increase of online recruitment during the Covid-19 pandemic .

I considered using paid incentives and targeted advertising which have been evidenced as a successful recruitment method in in other studies (Tully, Spyreli, & Allen-Walker, 2021). However, I was concerned about ethical implications associated with incentivising women to participate (Carlin *et al*, 2021). I observed that the participants in this study were largely driven by altruistic reasons or by wanting to tell their story. This is in line with the recognition of the therapeutic benefits of birth storytelling, which could also serve to minimise the researcher-participant power imbalance that often prevails in research interviews (Rogers, 2008).

2.5 Procedure and ethical considerations

Respondents to the study call were followed up to check for suitability and to receive an informal briefing regarding the study, such as amount of time it might take and the voluntary nature of the study. Following this, the participant information sheet and interview guide were sent to help the respondent make an informed decision as to whether they would like to participate. If they were still interested in partaking, a convenient time for them to be interviewed and audio recorded was arranged. Participants were then sent a written version of the privacy notice and consent form, verbal consent was obtained and recorded prior to interviews taking place. Debrief in the form of a thank you email containing contact details for relevant support organisations was sent to all

participants following their interviews (these documents can be found in appendices 4-7, pp 102-109.).

This study received full ethical approval from the Faculty of Health & Applied Science Research Ethics committee at the University of the West of England (UWE). The research also abides by BPS and HCPC ethical guidelines, as well as IPA procedures in ensuring participants' rights are upheld during the research process (Pietkiewicz & Smith, 2014).

2.6 Semi Structured interviews

Flexible, semi-structured interviews using open-ended questions were implemented in order to allow for deeper examination of women's experiences of living with slow healing CS wounds. Semi-structured interviews are the primary data collection tools in IPA research as this gives the participant enough freedom to explore subjective experiences while still adhering to topics within research boundaries (Smith, Flowers & Larkin, 2012; Pietkiewicz & Smith, 2012).

I designed the semi-structured interview schedule following input from two PPI members with lived experience of delayed Caesarean wound healing. The draft schedule was shared electronically with these two women, in addition to a midwife who acted as part of the PPI (please see appendix 1C,p.96, for a summary of PPI member backgrounds). Following amendment of the interview guide (please see matrix in appendix 1A, p.92) ,this was then piloted on one of the women with lived experience in order to test sensitivity and appropriateness of the questions. Overall, minor points for amendment related to terminology was revealed as a result of the pilot interview. However, this interview was not included as part of the final analysis, as the PPI member did not fit within the participant eligibility criteria (she gave birth more than two years of the interview taking place).

The interview schedule was sent to women who responded to the study call and fit the participation criteria, so they could make an informed decision as to whether they would like to participate in the study (interview guide can be found in appendix 8, p. 110). Interviews were then conducted in accordance with university guidelines for conducting research safely during the Covid-19 pandemic, this meant conducting interviews via phone or a UWE approved virtual platform (i.e. Microsoft Teams) based on each participant's preference. There were strengths and limitations to this approach; benefits included the ability to widen the recruitment pool which meant women from all over the UK were given the opportunity to participate, this would have not been possible if relying on face to face interviews. One significant weakness was being unable to observe telephone participants' visual cues (i.e. signs of distress or annoyance) which is of pertinence in research interviews (Musselwhite, Cuff, McGregor & King, 2007).

In order to ensure minimal disruption to participants' daily lives, steps included giving participants the option of undertaking the interview in more than one sitting.

Interview records were then transcribed verbatim, this process was undertaken solely by me as the first author of the Doctoral project.

2.7 Data analysis

For the purpose of data analysis, I followed a set of flexible, non-prescriptive guidelines advocated by Smith, Flowers & Larkins (2012) in conducting an IPA analysis. The first stage of analysis consists of reading and re-reading transcripts in order to '*immerse*' oneself within the narratives

(Smith, Flowers & Larkin, 2012, p. 82). This was followed by a free textual analysis; noting down immediate thoughts and themes that summarise the content of each narrative on the left hand margin of each transcript piece. The second stage consists of a more intellectual level of analysis involving abstraction of themes according to contextual relevancy, and noting these on the right hand margin (see example in appendix 9, p.111). This process of developing emergent themes requires magnifying sections of the transcript whilst still keeping a holistic grasp of the overall essence. Smith, Flowers and Larkin (2012) describe this process as a '*synergistic process of description and interpretation'* (p.92).

After listing these emergent themes in chronological order in a separate Word document (see Appendix 10A, p. 113), further bottom-up processing was undertaken in order to cluster the themes into more economical sub-ordinate themes, paying close attention to themes that interact with each other symbolically. Authors such as Smith and Osborn (2008) analogise this process using the laws of magnetism, with some themes pulling and attracting each other into clusters. Master headings were then formed based on careful consideration of how clusters within sub-ordinate themes supplement each other. Finally, checking themes with evidence from the transcripts in the form of quotations further allowed for expansion of themes into a coherent account (See appendix 10B, p.115). Smith, Flowers and Larkin (2012) describe this stage of coding and structuring data as a shift from the phenomenological positioning of immersing oneself within the participant's lived world, to an interpretative position whereby the investigator attempts to makes sense of participants' accounts as guided by the research question. It is important to note that in line with Dean, Smith and Payne's (2006) description of IPA being a fluid, iterative process, I found myself editing, combining and re-naming themes during the write-up and supervision process (see appendix 10 for audit trail, p.113).

2.8 Qualitative research rigour

In order to uphold the trustworthiness and quality of my research, I have adopted Yardley's (2000;2016) framework throughout the research project lifespan. In this section, I will demonstrate how I employed the four comprehensive principles as advocated by Yardley:

1. *Sensitivity and context*: I abided by UWE, HCPC and IPA guidelines in conducting interviews ethically. My training in humanistic counselling coupled with my experience as a behavioural therapist has armed me with awareness of potential power imbalances between the interviewer and interviewee, as well as skills in minimising this. For example, checking participant consent to continue should I notice signs of distress.
2. *Commitment and rigour*: I ensured my study remained rigorous by i.e. screening potential participants in order to endorse homogeneity in accordance with IPA underpinnings. Participant profiles in the form of individual brief case studies were sent to the participants in order to check for accuracy and minimise researcher bias. However it is worth noting that the practice of member checking is widely debated with some authors arguing that inviting participants to review transcripts and findings is against the IPA spirit in apprehending '*immediate, original data of our consciousness'* (Pickles, 1985:,p.95 in Snow, 2009).
3. *Transparency and coherence*: An 'audit trail' of reflexivity and decision-making in order to make transparent the 'double hermeneutic' processing can be found in appendices 9-10 (pp. 111-113). An independent auditor who is a health psychologist with experience of conducting qualitative research, but was not connected to the study or holds any expertise in the topic, was invited to ensure the study findings are credible

4. *Impact and importance:* In order to ensure my study is meaningful, PPI members and other relevant key stakeholder (i.e. gatekeepers, participants) had an active role in steering the study throughout.

2.9 Reflexivity

IPA is rooted within the Heideggerian scholarship that maintains the researcher as part of the hermeneutic circle. As such, interpretation of participants’ stories is the product of the researcher’s sense-making, that is in turn influenced by the researcher ‘horizontals’ or presumptions and innate perceptions and unconscious biases. In this sense, the researcher has an ethical responsibility to make as transparent as possible their positioning through reflexivity (Smith, Flowers & Larkin, 2012).

It is acknowledged that if done correctly, reflexivity can augment the quality of research as this flexes the researcher’s sense of ‘being’ in the hermeneutic circle. Reflexivity is also a key tenet of rigorous qualitative studies; as readers are invited to arrive at their own interpretation into the trustworthiness and credibility of findings as part of the hermeneutic cycle (Shinebourne, 2011). Furthermore, Burgess-Proctor (2015) argues that reflexivity is of particular pertinence in feminist research that aims to minimise the hierarchical gap between participant and academic researcher. To this end, the researcher must be cautious in falling in the trap of aiming to describe or defend the absolute truths of participants’ narratives. It is argued that these type of reflections are more in line with positivist approaches, and therefore paradoxical to feminist research ambitions in prioritising the rawness of idiographic voices. Goldspink and Engward (2019, p226) state that ‘*blunt disclosure in itself is not enough to resolve influencing preconceptions’*, but in the same line warn that ‘*clumsy reflexivity is unhelpful to the research.*’ But how much constitutes shallow reflectiveness, and how much is ‘*endless narcissistic personal emoting’*? I was very much comforted by Mitchell’s (2021) statement that many novice researchers are anxious about getting the right balance in reflexivity.

So forth, I will firstly make clear that though I have gone through the process of childbirth twice, I have never experienced a CB. From a clinical perspective, my births were straightforward vaginal births, causing no lasting physical damage apart from expected side effects of bearing a child. I was very cautious about disclosing this to participants, due to findings in literature surrounding the phenomenon of ‘birth competitiveness’ (Weckesser *et al*, 2019). In this sense, I was conscious about my dual identity as a researcher and mother positioned within the normative assumptions of vaginal births as the superior and ‘normalised’ method of giving birth. Admittedly, this made me feel somewhat like an ‘outsider’ in my research. On one hand, I felt this was advantageous as I felt I was able to provide a viewpoint from a subjective angle. This strength was also pointed out by a woman with lived experience of poor Caesarean wound healing that acted as part of the study PPI, who went on to explain that her current discussions surrounding the subject are confined to others with similar experiences and views. However, Dwyer and Buckle (2009) also argue that being an ‘outsider’ could mean less rapport built between researcher and participants, who may feel more comfortable disclosing sensitive matters to someone who has gone through their experience.

Nevertheless, I abided by my therapeutic training ethical code of avoiding self-disclosure in order to provide the participant with a blank canvas to promote self-reflection. This was not always possible due to me providing some of the interviews out of school hours from home, meaning on

some occasions background noise coming from my own household was discernible. Of course, as more than half of the participants (N=4) were recruited via word of mouth from my own social circle, I cannot discount the fact that these participants had some level of knowledge about my personal situation. I felt this was obvious in my interview with Maura. I couldn't help but feel that her constant self-reference as a 'health professional' juggling studies (as disclosed after the interview), a career and motherhood was her recognition and bridging of our similar backgrounds. In this effect, I felt that my interview with Maura was perhaps one I enjoyed most due to the easy and natural flow of our conversation. Similarly, Shaw (2010) also provided a reflexive account of her experience as a mother/ researcher interviewing young mothers as part of her research. I found this paper interesting as I could relate to Shaw's efforts of consciously not transplanting herself within the narratives of women she felt she could relate to, whilst at the same time not sacrificing her connectedness to the research.

From a more professional perspective, my knowledge of the working culture and challenges specific to the midwives in the antenatal care trust I work closely with has most likely coloured my way of 'being' in this research. Similarly, my paid role providing therapeutic support to clients over the phone or video call meant that I had to constantly remind myself of my role as a researcher during the interview and resist the 'therapist reflex' (Wagstaff *et al*, 2014). On this note, I found supervision sessions beneficial in easing the strong sense of guilt I felt in not being able to offer interviewees a pathway to a solution, despite findings that mothers can find talking about traumatic birth events therapeutic (i.e. Johnson, Scott & Brann, 2020; Callister, 2004).

3 Results

This chapter discusses findings in answer to the research objective in exploring new mothers' lived experience of slow-to-heal CB wounds. Current literature references are integrated into this result section, in order to give context to terminology that is embedded within participants' paradigms.

3.1 Participants

Interviews with seven (N=7) women were conducted between October 2021 and June 2022, most interviews were approximately 1 hour in length (ranging from 34 minutes to 1 hour and 11 minutes). Most interviewees identified as White (N=6), and one as Black (N=1). The majority were living with a partner during the period being investigated (N=6), including one woman in a same-sex marriage. Most (N=5) were in employment or self-employed, one worked up until birth, and one was a homemaker (see figure 1 below). As per the study eligibility criteria, all women had given birth in the two years prior to interviews taking place meaning women's experiences of care were framed within the context of the Covid-19 pandemic.

Pseudonyms are used throughout in order to protect the participants' anonymity.

Brief participant case studies have been included in appendix 11 (p. 194), in order to give readers an essence of idiographic experience, and to allow deeper insight into commonalities and divergences across narratives. The case studies and demographic summary were sent back to participants to verify, in order to uphold the rigour this qualitative research (see section 2.8). Out of the 7 participants, 6 responded to the email. These participants confirmed that the brief summaries were representative of their experiences.

Though information regarding clinical vulnerability was not methodologically captured, none of the participants reported having high risk pregnancies, nor themselves or their newborns needing critical care intervention following birth. Therefore, from a medical standpoint, these participants could be considered of low-level need and not characteristic of women more likely to present with delayed wound healing following operative birth (i.e. those with gestational diabetes; Bullough, Wilkinson, Wan & Burns, 2014).

Pseudonym	Age at interview	Infant age at interview/ length of time since CB	Type of Caesarean(repeat/ planned/ unplanned),	Parity	Ethnicity	Relationship status at birth	Description of clinical wound healing issues
Charlotte	37	32 weeks (7 months)	Repeat/ unplanned	Multipara	White British	Married	Prolonged pain and infection contributing to delay in wound closure.
Amanda	29	12 weeks (3 months)	Repeat/ unplanned	Multipara	White Other	Co-habiting	Prolonged wound pain
Sarah	30	48 weeks (11 months)	Repeat/ planned	Multipara	White British	Single	Prolonged pain and early infection contributing towards delay in wound healing
Maura	37	69.5 weeks (16 months)	Unplanned	Primipara	White Irish	Married	Prolonged pain and delay in wound closure at surgical scar site
Tina	35	35 weeks (8 months)	Repeat/ planned	Multipara	Black British	Married	Probable infection continued by wound seepage following removal of surgical staples
Harriet	36	61 weeks (14 months)	Repeat/ planned	Multipara	White British	Co-habiting	Delayed wound closure and prolonged bleeding from wound site.
Lisa	38	91 weeks (21 months)	Unplanned	Primipara	White British	Married	Prolonged wound pain and probable surgical site infection

Figure 1: Participant summary table

3.2 Findings

Analysis of women's narratives revealed three overriding themes of '*Tied to that event': healing physical and emotional wounds*; The '*good mother' and the 'good patient': negotiating being a carer and being cared for*; and lastly *Adjusting to a new normality*. Seven subordinate themes emerged from the three superordinate themes which attempt to illustrate the unique biopsychosocial experience of new mothers living with a slow-to-heal Caesarean wound. A diagram depicting inter-relatedness between themes can be found below (see figure 2). Convergences and divergences within and across narratives are also explored in order to attach a holistic view of what these experiences mean for this population group and those caring for them.

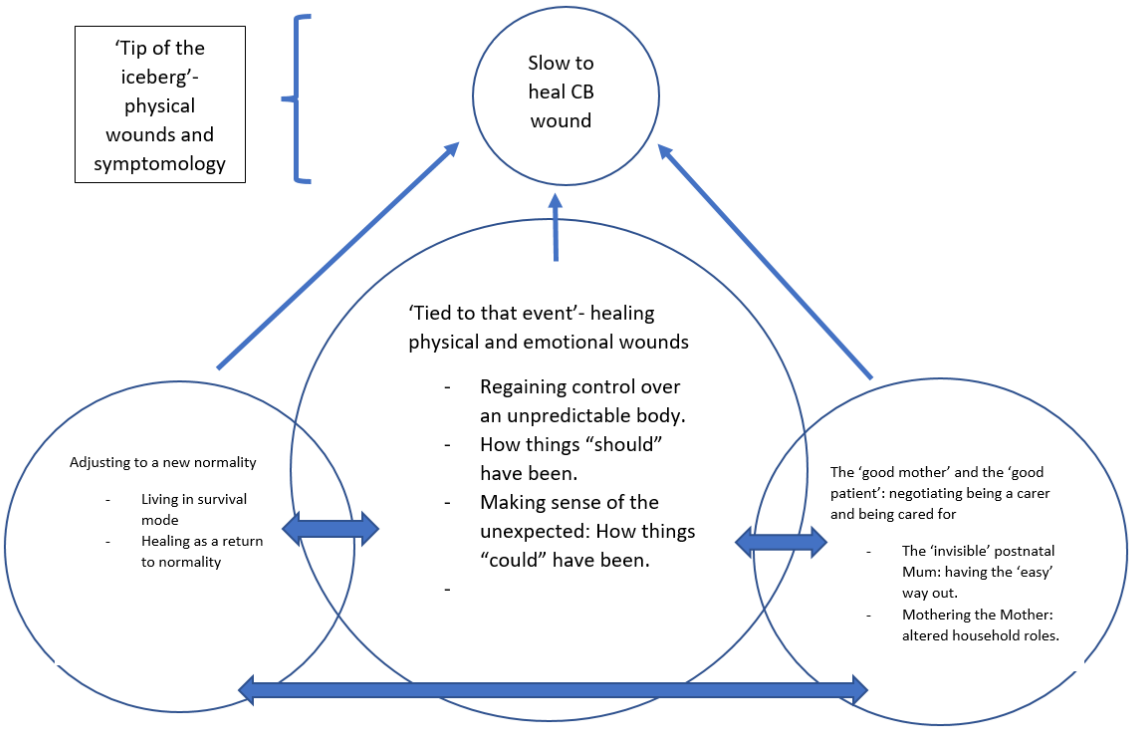

Figure 2: IPA theme diagram

3.2.1 'Tied to that event': healing physical and emotional wounds

The semi structured interviews started with a question regarding women's CB in order to frame the topic. However, a clear pattern emerged across the women's accounts of their birth experience. This not only set the tone for their recovery storyline, the women's recounting of their slow recovery was likewise interjected with birth narratives throughout; thus becoming part of women's meaning making through birth stories. Maura's statement '*Tied to that event*' summarises in a few words how slow recovery is deeply anchored within the context of individual women's birth experiences. Healing physical and emotional wounds captures the mind-body connectivity apparent in the lived experience of delayed recovery from a CB.

3.2.1.1 Regaining control over an unpredictable body

The women who underwent an unplanned Caesarean recounted how loss of control over their bodies started when birthing decisions were taken out of their hands. The women who planned their Caesarean procedures described this as an attempt to take back control over their bodies following a previous unplanned Caesarean or traumatic birth.

The women in this study described how the loss of agency over their complex healing wounds started shortly after birth. This was marked by graphic recollections of seeing their wounds for the first time, or intense emotions in noticing wound related complications. Alterations to body shape and function are expected during the puerperal period (i.e. lactogenesis; NHS, 2019), and for the post-surgical patient, pain and changes to wound appearance over time are considered normal healing trajectories (Grey, Enoch & Harding, 2006). However, the women interviewed used words

such as ‘*puss-y’*, and ‘*gushing*’ to describe their sense of shock and aversion over their bodies that had suddenly become unknown and unpredictable. The women described the physicality of their wounds, such as extremity of bruising, to convey the psychological impact it had at the time:

‘*first time that I noticed that it was going all black and gooey, I was like- that doesn’t look right, um, like I’ve got a picture of um, of my, of the area, and it’s all black and red, it looks horrendous… mine (wound) just looked like a complete war scene’* (Harriet).

Harriet’s description of her wound as a *‘war scene’* brings to light not only the physical severity of the wound, but can also be interpreted as a metaphorical battle in regaining control over her own body. As well as the physical appearance of the wound area, pain also featured strongly in most women’s narratives. The women emphasised the intensity at the time, with pain being described as over-bearing and extreme:

'I’ve never experienced pain like it, it was like a hot poker, every single time, the whole way through m.. my stomach, it was excruciating, and it wouldn’t just go away, it would linger for maybe 15, 20 seconds, and that same intensity, and that lasted.. God that lasted for about a month.' (Maura)

Maura’s extract above describes very vividly her experience of Caesarean surgical wound pain; she starts off by separating this type of wound pain from other instances of pain she has ever experienced. Her choice of using the analogy ‘*like a red hot poker’,* instead of simple descriptive words such as ‘burning’ and ‘searing’ brings to mind torture and a strong element of lack of control. This was emphasised by time connotations such as ‘*it wouldn’t just go away’*, ‘*linger*’ followed by a pronounced pause before her reflections on how long this went on for; suggesting that loss of control over the pain related to both intensity and longevity of the symptom.

As elucidated in the extract above, continuation or lack of improvement of these unexpected symptoms exacerbated the sense of helplessness and anxiety in dealing with the unknown. The concept of never-ending healing was described as the sense of isolation and angst women felt in pondering if and when the wound will heal, and what impact this will have, both practical and psychological as illustrated by Charlotte’s and Harriet’s extracts below:

'That was my point.. how long am I supposed to take lots of Nurofen and things for it, you know, is it something that’s ok to take for years to come or like,’ (Charlotte).

‘*It was just I think whilst it was still bleeding you think- is it always going to bleed? Is it never going to get better? Is it going to get worse*?’ (Harriet)

Lasting symptoms including constant wound site pain seem to hold figurative meaning for the women in connection to their CB. For example, Charlotte’s use of the word ‘*pain*’ in the extract below seems to hold double meaning - pain in relation to the physical wound, but also painful emotions in relation to feeling let down again by a body that is perceived as dysfunctional:

‘*so the emotional side is that frustration, and I suppose a bit of anger, you’ve had another Caesarean, especially one that hasn’t healed properly, so that’s caused more pain*’ (Charlotte).

Amanda also adds to the understanding of the dual relationship between pro-longed symptomatology and birth disappointment:

'I don’t know if I’ll think about the pain differently, but I’ll think about the experience differently, okay, I’ll think about the experience differently, and I guess you’d be more.. maybe you’d be more accepting of the pain, I can’t explain it, I know it sounds weird, but you’re sort of like, okay, it’s one thing to deal with, rather than having to deal with the pain and mentally the thoughts that you have.. Because of the experience that you have with the whole situation' (Amanda).

It is clear that Amanda was struggling to put into words the connection between persistent pain she was experiencing and her unwanted Caesarean. What is interesting from Amanda’s reflections is her realisation that the way she processes her wound site pain is emotively linked, and contributes towards her negative feelings towards her CB. Later on in the interview, she offers further insight on how ongoing wound pain serves as a constant reminder that a meaningful event had not gone as planned:

‘it’s I suppose because of the pain it’s a reminder, it’s a constant, it’s just there’ (Amanda)

These findings suggest a holistic lens is needed to understand the needs of women with slow healing Caesarean wounds. The themes below will further discuss the reciprocal relationship between psychological acceptance of the Caesarean and resulting wounds, which may in turn influence women’s resilience and perceptions of how well their wounds are healing.

3.2.1.2 How things “should” have been

All of the mothers interviewed had a pre-conceived idea of what the birth and postpartum period should be like. For the women that underwent an unplanned Caesarean, a vaginal birth followed by a swift recovery was the expectation. Even women that had planned their CB anticipated that their recovery would be an improved experience from their previous traumatic births. For example, Sarah used the wordings ‘*smooth sailing’* frequently in her interview to describe how she did not expect post-partum complications, as her second pregnancy was unlike her more complex first pregnancy. Similarly, Maura constantly reflected on a healthy, clinically uneventful pregnancy to contrast her postpartum experiences.

These women expressed alarm and disbelief in registering the turn of events, as well as lack of preparation for the level and length of time they had to endure life disruptions caused by wound healing issues. It is clear from most women’s interviews that how they had imagined the postpartum period to be differed widely from the experience of recovering from a slow-to-heal Caesarean wound:

'I didn’t expect it to be like a walk in the park and there not to be any pain or whatever, but just to be.. I was just, basically immobile, for such a long time’ (Lisa)

It is apparent from this extract that Lisa, one of only two participants who were first time mothers at the time of interview, felt the need to clarify that her experience of persistent wound pain was not exaggerated nor the product of unrealistic expectations. Lisa goes on to describe the emotional consequence, notably the strong sense of loss of quality time during what should be an important bonding period. Her repeated use of the word ‘*responsive’* suggests a disrupted sense of selfhood as Lisa was unable to be the parent she had envisaged due to slow wound healing:

‘*there’s been a lot of grief for things that had been lost, that cannot be reclaimed.. we chosen to be as responsive, kind of gentle parenting, responsive parenting, and to not be able to respond to her, as quickly as I wanted to, um, or even at times at all’* (Lisa)

The emotional fallout ranging between anger, disappointment and sadness was also prevalent across most of the other women’s accounts. Similar to Lisa’s narrative, Amanda also suggests a sense of failure and internalisation over not being able to achieve a preconceived postpartum image:

‘*I felt like everything I was doing wasn’t good enough, you know, because everything just wasn’t right. I had.. I had something in my mind of what I wanted, and that was to have a vaginal birth, and to be able to walk around, look after my older child, you know*,’ (Amanda)

On the contrary, Tina’s frequent use of the phrases *‘it is what it is’* and going ‘*with the flow’* depicts her acceptance over loss of control over her wound healing:

‘*it’s C-Section, so um, it can take up to God knows how long for it to heal properly, so I didn’t have like um, I didn’t have like a time limit to say oh, like 2 weeks this needs to be healed, so I was just like… going with it really*.’ (Tina)

Tina’s extract above is in contrast to most of the other mothers’ accounts citing NHS guidance of six weeks as the benchmark for resumption of daily roles, which was not achieved by the women in the study. On this note, most of the women in this study, apart from Tina, reflected an exacerbated sense of disconnection when comparing other women’s post-Caesarean recovery experiences to their own, as exemplified by Harriet:

‘*I’ve had a number of friends that have all had C-sections and they’re walking around a couple of days later absolutely fine, whereas I still looked like an old lady*.’ (Harriet)

It is clear that the embodiment of how things ‘should have been’ during the postpartum period is gleaned from normative sources such as social media, which will be discussed further in the sub-theme below.

3.2.1.3 Making sense of the unexpected: How things “could” have been

In literature it is well established that some women who have had unplanned Caesareans need to understand the underlying reasons as a way of obtaining emotional closure (Djatmika, Lusher, Meyrick & Byron-Daniels, 2021; Carlgren & Berg, 2008). From the women’s narratives, it can be rationalised that women undergoing complex recovery may have a similar need in order to come to terms with loss over an envisioned ‘honeymoon’ period with their new family unit as discussed in the previous sub-theme. In their interviews, most of the women strived to make sense of how they had acquired a slow healing Caesarean wound, and described their attempts at problem solving their unprecedented situation. Women’s reflections on how much control they had over how things “could” have been was often conflicting and contradictory within narratives:

‘*I think there’s a lot of people that, like I did, still do, think that childbirth couldn’t.. Shouldn’t go this way, and maybe.. I think there’s sometimes too much intervention, too early, and then.. Like your body the way it’s shape, like different pelvises, I’ve learnt since about different shaped pelvises and how they are in the body, and there’s very many factors that I didn’t understand, you know, it’s not just as easy as you go into labour and the baby is just going to come on out, it’s very*

much like.. I think some people are quite, you know.. their bodies work that way and things go smoothly and I think some people, it doesn't work out for..' (Charlotte).

On the one hand, Charlotte's extract summarises women's experiences of self-blame. Delayed healing was caused by their own body 'failings'. For example, a body that necessitated surgical intervention at birth resulting in a slow-to-heal wound, or from damage caused by a previous Caesarean. On the other hand, women reflected how surgical birth leading up to complex healing was not under their control, but rather dictated by wider systematic pressures such as obstetricians' preferences for Caesarean procedures. To this end, some of the women blamed healthcare staffs' neglect or poor practice as the root cause of the issue, such as failed anaesthesia or previous clinical errors. Themes of regret were powerful in some of the women's narratives as they reflected on how their situation could have been avoided if they had made different historical decisions, such as avoiding their first CB. Ultimately, *'hindsight is a wonderful thing'* (Harriet) summarises a sense of resignation among some of the women that their slow healing wound was not within the norm and therefore not within their remit to predict.

There was also a sense that some of the women in this study felt that their bodies had become clinical property during the Caesarean procedure, which was further compounded by women's feelings of dependence on medical guidance in their attempt to fathom their post-surgical wound issues. In order to regain control, women reported seeking alternative sources of information and support to increase knowledge, seek reassurance and de-mystify their condition. Often these sources were informal and lacked clinical credibility and reliability, such as the counsel of other friends, family and the internet. It is clear that the informational needs of the women in this study were not being met, as evidenced by most women expressing confusion over clinical prognosis and reporting lack of confidence in attending to the wound at home.

Consequently, most of the women in this study questioned the appropriateness of the way information was given. Women that had not planned their CBs admitted to not absorbing surgical birth related information during antenatal classes as they were biased towards vaginal birth. Those that received information in the delivery ward reported feeling too overwhelmed to process information. In addition, the women conveyed needing emotional support and practical information that transgresses the standard '*surface area'* (Harriet) post-Caesarean resources:

'*so it's very much just um, guesswork really, um, whereas if that happens, you know, if your c-section scar gets infected or if it's bleeding a lot for a long period of time, you should be given a leaflet with information about how best to care for it, and what you need to be careful about and what is the red, you know, what's a red alert if it gets worse, you know, what are the indicators of that, but there's nothing like that, so..*' (Harriet)

Harriet's tone and use of the wording '*guesswork*' reveals a sense of disempowerment over lack of clinical postnatal intervention and information. This compares vividly with the sense of loss of confidence resulting from over-medicalisation of the birthing process, which was a similar finding in the other narratives. Harriet trailed off at the end of her reflection, marking the sense of despair and resignation at being made to feel like an anomaly due to lack of appropriate information for her condition.

In summary, the theme *'Tied to that event': healing physical and emotional wounds* sheds light on how women's idiosyncratic birth experiences and expectations coloured their aptitude towards their slow healing wounds, with delayed recovery becoming part and parcel of the overall CB

narrative. This is compounded by the women's sense-making of how things "could" have and "should" have been as dictated by systems and societal fabrics that are not geared towards complex post-Caesarean healing.

The next theme will discuss in more detail women's configuration of self in the face of conflicting positioning as both 'patient' (someone being looked after) and 'mother' (someone looking after others).

3.2.2 The 'good mother' and the 'good patient': negotiating being a carer and being cared for.

Studies ascertain how maternal adjustment is contingent on successful reconfiguring of the self in relation to how society deems a 'good mother' should be (see section 1.2.5.3). The transition towards becoming a mother can also be equivocally upheld or disrupted by those around her responsible for her care during the vulnerable postnatal weeks, including family and healthcare staff (McLeish, Harvey, Redshaw, Alderdice, 2021; Taubman, Navon, Davidi, 2021; Furuta, Sandall & Bick, 2014)., Thus, synonymous to the concept of being a 'good mother', the 'good patient' is traditionally described in literature as a person who is in essence accepting of medical advice without being challenging or a burden to omnipotent clinicians (Sointu, 2017; Brown, Tanner & Padley, 2014). In summary, it is up to the new mother to monitor her feelings and behaviour in order to achieve harmonious alignment with other's expectations.

Women's narratives surrounding slow Caesarean recovery indicated nuances of how the women in this study adapted towards their own subjective notion of what a 'good mother' should be within their family structures, whilst negotiating professional relationships with healthcare staff in the unique context of presenting with additional needs compared to the generic post-Caesarean maternity population.

3.2.1.4 The invisible postnatal Mum: having the 'easy way out'

The women in this study described how relationship dynamics with healthcare staff were formed prior to the birth and extended into their postpartum experience of seeking care for their slow healing Caesarean wounds. For most of the interviewees, experience with professionals involved in their post-operative wound care was mixed, with the women identifying both negative and positive interactions within their accounts.

Positive interactions with professionals were characterised as being treated as an individual, and women having their concerns listened to and taken seriously. It became clear from women's narratives that positive engagement did not necessarily mean that healthcare staff were able to provide a satisfactory solution to wound healing issues, but rather were able to provide women with tools to deal with their circumstances better. As an example, Lisa recalled how she felt reassured after her National Childbirth Trust (NCT) coach empathised by disclosing her own experience of healing from an emergency Caesarean.

On this note, quality of patient-doctor communication has frequently been flagged as a factor underlying new mothers' satisfaction with information and preparedness for the postnatal period (Djatmika, Lusher, Meyrick & Byron-Daniels, 2021; Rouhi, Stirling, Crisp, 2019). Consonant with this, most of the women in this study expressed how poor or one-sided communication (i.e. being *'spoken at'*) with healthcare professionals contributed to feelings of isolation and loss of agency

over wound management. An example of this is provided by two of the women's accounts of seeking urgent care in the early postpartum period due to issues with their post-Caesarean wound. The women, Sarah and Harriet, reported feelings of intense anxiety, including fearing for their own life and distress at leaving their new-born behind. There was a sense of bafflement in the way these women recalled these '*scary*' (Sarah) episodes, as they reflected how they were treated with indifference by urgent care staff and came out of the experience still not understanding why or how to mitigate their physical symptoms better:

'*so I went to hospital, and they looked at it, and they just said- oh you know, it's just um, it's just taking a bit of time to heal, it will be fine, um, just go home, so I said-ok, and then, this blood.. pushing out, what do.. what I do with it? Do I.. Do I have to dress it? Do I have to put a plaster or pad on it? They're like- you know what, just put a sanitary pad on it, it will be fine, and I was like- oh..kay*' (Harriet).

The plethora of questions and sense of panic observed in Harriet's extract above, is a stark contrast to the healthcare staff's casual response, suggesting indifference. A similar pattern emerged across the women's descriptions of interaction with a variety of healthcare staff as they sought support and guidance for their wound related concerns. This points to detachment between the emotive responses of women and healthcare staff, with staff failing to recognise the psychological burden caused by complex wound symptomology. As indicated in Maura's extract below, negative interactions were demonstrated by staff (in this case her GP) being perceived as disinvested and not empathically listening to the woman's concerns:

'*he made me feel like I was a bit of a nuisance, like silly woman, you know, what are you talking about (laughs), it's fine, you know, it's fine, oh yeah, it looks fine, but he barely glanced at it (wound), and I was just like- oh*? (Maura)

Maura's reflection of how she was made to feel like a '*nuisance*' and '*silly woman'* adds to the understanding of how women are made to feel they are '*dramatising*' (Sarah) and over-exaggerating their concerns in the first place.

For the most part, women in this study reported being unable to quantify or explain in medical terms why they felt their healing process was irregular. Instead, some relied on intuition, or the sense that something did not 'seem right', whilst those with a repeat Caesarean used their previous postpartum experience as a proxy for healing progress. These women described power struggles as their concerns were downplayed by professionals as the gatekeepers of medical knowledge. Some of the women felt that healthcare staff were giving advice based on generic '*tick box*' (Charlotte) clinical guidance and were not able to cater to their individual needs, resulting in women feeling like an anomaly.

Overall, there was a shared belief amongst most of the women in this study that society as a whole perceived CBs as the inferior, pain-free alternative to vaginal delivery. They interpreted healthcare staffs' dismissive attitudes as part of the wider philosophy that women seek a Caesarean in order to take the '*easy way out'* (Charlotte and Amanda), or that a safe delivery is an appropriate trade-off for delayed recovery:

'*I don't get it, I don't get how you, you know, if I had an operation for something else and had to go back having it you know, checked out, and have a wound looked at a later date, I think there would be a lot more around.. You know, has it healed, has the operation.. Has it gone as expected, that's what it is, if you had a planned operation and you had a follow-up appointment, you're*

checking, you know.. you have this problem, do you still have this problem? Has it healed? You know, what are the next steps with it, there is no follow up, there is no after care.' (Charlotte).

Charlotte's frustration is illustrated in her repeat of the words *'I don't get it'* as she questions the difference in attitudes towards mothers that have given birth via Caesarean in comparison to generic post-surgical patients. Again, there exists a notable contrast in Charlotte's narrative of assisted birth with '*lots of tubey things in and out of every arm and everywhere*' versus lack of clinical assistance post Caesarean when she sought medical intervention.

Lastly, it should be noted that all of the women interviewed were impacted by changes to healthcare service provision due to Covid-19 regulations. Suspension of face-to-face services contributed towards women feeling even more invisible and abandoned by healthcare staff during a time of prolonged vulnerability. However, there was a sense that the women as 'good patients' discounted or tried to put their negative care experiences into perspective by considering the added pressures faced by NHS staff during the pandemic:

'*when I had (baby) it was beginning of lockdown and what not, so the midwives they were not really sure what was going on? so um, I think they tried their best to be honest, they were quite um, helpful, apart from obviously not taking care of my wound, but apart from that they were really helpful'* (Tina)

3.2.1.5 Mothering the Mother: altered household roles

The early postpartum is described as a period of 'psychological upheaval' characterised by reconfiguration of a new mother's social roles and establishment of role boundaries within the household (Perun, 2013).

The women's narratives in this study richly illustrate how 'good mother / wife' roles were negotiated and reconciled during a time of extended disruptions to daily life. In general, there was a sense of a relationship dynamic change from pre-birth to the slow recovery stage, amongst both first time and repeat Caesarean mothers. Preceding the birth, partners (or family and friends in the absence of a partner) were described as a necessity in decision-making, and as essential in re-balancing the power disequilibrium apparent between healthcare professionals and the mothers-to-be. There was a sense of vulnerability as partner presence was restricted at antenatal appointments, the birth procedure and in delivery wards due to Covid-19 social distancing measures. It could be observed from the women's accounts that perceived support needs shifted during the postnatal period, as the women attempted to inaugurate themselves as matriarch of the household and navigated professional relationships independently (i.e. attend postnatal appointments alone).

While most studies focus on maternal satisfaction with male partners' contribution towards what is traditionally classed as feminine labour dominions (i.e. house cleaning, childcare), Cohen *et al* (2019) argue that the concept of role satisfaction is achieved when the woman's subjective beliefs of ideal household labour division is actualised. In other words, it is how meaningful household role attainment is to the identity of the new mother that will facilitate maternal adjustment.

In concordance with this, there were similarities and contrasts across and within women's accounts that illustrate how 'good mothering' roles are internalised as part of the idiographic motherhood experience of healing from a complex Caesarean wound.

For example, some of the women's statements such as '*we split things 50-50 and stuff*' (Tina) and '*I'm lucky that my fiancé got the memo that it's the 21st century and men need to be hands on'* (Harriet) insinuates an implicit division of household tasks that is congruent with modern family values. Tina's account in particular demonstrated how the wound healing process became a joint responsibility with her husband not only providing practical support, but also taking ownership of the slow healing wound:

'I trusted my husband's.. My husband's instinct to be honest, yeah, so if he said to me about, if he said that it's um, it's getting better so I just go with that, or if he says that um, there's something wrong with it then he will just keep an eye on it and then um, if it was getting worse with it then we get um, the midwife involved' (Tina).

Similarly, Lisa's extract below also summarises the highs and lows of intrinsic sharing of the physical and emotional burden of prolonged recovery with her partner:

'*you know really strengthened us in many ways, as team, but it also really stretched us, so both of us were just so depleted'* (Lisa).

However, it became clear from most of the women's narratives that there were boundaries in regard to maternal role distribution within the family home. For example, Amanda's reflection on how her partner's below par housekeeping contributed towards declining well-being suggested loss of agency over set roles within her household. Despite most of the women's suggestion that they have eschewed traditional gendered roles, the role reversal that was apparent as the women's partners took on primary caregiving responsibilities seemed sacrilege and more difficult for the women to accept. The sense of distress and guilt resulting from the women's compromised ability to fulfil mothering roles while recovering with slow healing surgical wounds was notable, especially within the narratives of women that had to negotiate caring for older children as well. There was a sense that these women felt continued role reversal in care giving duties caused long-term alterations within the family unit relationship dynamics:

'*that makes me really sad that he (older child), you know, he doesn't want to come to me, he wants to go to his Daddy all the time, so I suppose um, you know, when I was recovering you know, he wanted me to pick him up and I said – I can't pick you up, you have to go to Daddy, so that's, that's a big dynamic change where, um, I wasn't mummy to him how I should have been mummy to him*' (Harriet).

Harriet's description of how she '*should have been'* was particularly poignant; the sense of displacement was also apparent in most of the other women's accounts as they contemplated their sense of selves within the family structure before, during and after the slow healing wound recovery. For example, most of the women required support from the wider family network due to the extent of their physical limitations. While Maura described positive feelings of being cared for while her wider family rallied around to support her, some of the women expressed feeling like a burden and a yearning for space to bond with their new nuclear family unit undisrupted. This narrative was particularly visible in Sarah's account, the only interviewee that was a lone parent at the time of her CB. Sarah reported being conscious of monetary and time sacrifices her family members had to forego in order to care for her during her slow recovery. Moreover, Sarah reflected on how she felt she had regressed back to a '*childlike'* state as her mother became the main household carer, and it was apparent that this was in conflict to her self-concept as the mother figure of her own household:

‘ *I felt so vulnerable, like.. it’s the whole, like can’t explain, but it just makes you feel so vulnerable and like helpless towards yourself, and you’re just sort of standing there, like and someone else is taking control over the things that you do for yourself, it’s a really like horrible experience, you know*?’ (Sarah)

The women’s postnatal situation in the context of Covid-19 regulations varied with some of the women feeling their social support options were restricted, exacerbating feelings of isolation and loss of control. For others such as Maura, pandemic regulations offered an opportunity to recuperate without the added societal pressures that would be relevant under normal circumstances (i.e. hosting visitors). Maura used the word ‘*cocooned*’ to describe the sense of warmth and comfort provided by her small circle of friends and family during the pandemic. Whilst other mothers described the struggle of navigating the unknown and unpredictable, the term ‘*cocoon*’ can suggest positive emergence from a difficult transition. This narrative supports literature surrounding the cyclical relationship between interpersonal warmth and personal growth in the face of a challenging event (Taubman, Navon, Davidi, 2021)

Overall, women’s accounts on how maternal role adjustment was negotiated in light of prolonged physical morbidities varied according to women’s subjective expectations, family norms and situation. These findings add to existing studies that claim maternal satisfaction is derived from social support by suggesting that prolonged family or spousal support can have a detrimental impact on maternal confidence. For example, negative accounts were hallmarked by a conflict between sense of appreciation for the help of significant others and feelings of grief when ‘good mothering’ standards were not attained.

The next theme will elaborate on the psychosocial impact of living with a chronic wounded body on maternal role adjustment.

3.2.3 Adjusting to a new normality

In line with existing maternal transition theories (see section 1.2.5.3), the sub-theme ‘*Living in survival’ mode* illustrates how the women in this study negotiated disrupted attainment of maternal roles due to prolonged physical restrictions. The sub-theme *healing as a return to ‘normality’* describes the women’s aspirations and re-configuration of expectations as they learned to live with altered social and psychical functioning.

3.2.1.6 Living in survival mode

As pinpointed in previous themes, first time mothers in this study described the postnatal period as a time of finding one’s feet as a new parent. Likewise, multiparas illustrated how for them it was nevertheless still a learning curve in catering to an expanded family’s needs; all the while also exploring and learning to live within the boundaries of an altered body. Some of the women described the ongoing struggle of operating standard baby equipment and routines (i.e. taking children in and out car seats), which made them feel even more of an outsider in a society where vaginal birth is idealised and Caesareans are ironically seen as the ‘easier’ option. The women in the study described the practical adjustments they had to make to daily life routines in order to be able to fulfil their roles as new mothers as independently as possible. For the most part, there was a sense that these arrangements were far from the ideal the women had envisaged, but

nonetheless they had to 'make do' considering the circumstances. Some of the women used expressions such as being on '*autopilot'* (Maura) to indicate prolonged healing as a continuation of the sense of displacement and numbness experienced from the emergency Caesarean procedure. Expressions such as '*firefighting*' (Lisa) and '*survival mode'* (Harriet) were used frequently by most of the women to describe the sense of living in the remnants of a battle, whereby the focus of everyday life is regaining some sense of normality:

'*I think that it's just a tangled web, of emotions, when you're.. When it's that early on, you're caring for a new-born, um your recovery is rubbish, so.. you just feel, you're just in survival mode, it's as simple as that, it's just pure survival at that.. there's no quality of life, at all, you just feel like- if I could just put one foot in front of the other, just get through today, tomorrow is one step closer to recovery'* (Harriet)

As touched on in Harriet's extract above, a few of the women also described their awareness of how a cocktail of interactive postnatal side-effects such as lack of sleep, fatigue and hormonal oscillations contributed to a decreased sense of resilience and mental aptitude in coping with their situation:

'*I think it makes all of that a lot harder, the usual once you've given birth kind of hormone fluctuations, and the tiredness and lack of sleep, and then you throw that in as well, the wound and then it not healing, and the pain, it just makes you so much more.. I don't know, I suppose a lot more miserable, a lot less able to cope with certain things, erm…It's harder to feel a bit more.. I don't know how to explain it*…' (Charlotte).

Like Charlotte, most of the other women described the complexity of their feelings at the time in retrospect. As an example, Maura used the wording '*whirlwind*' to hint at a sense of powerlessness over her situation while Sarah's extract '*On one sense it felt like a blur because the days just rolled into other days'* described the monotony of daily life imbued by immobility. These accounts insinuate a sense that time has a different quality during a slow recovery process. Despite the repetitiveness and sense of imprisonment, there was no opportunity for women to process their emotions at the time. Maura's explanation of how she '*just got on with it'* and similarly Lisa's choice of the wording *'soldiered on'* illustrate how for the women in this study, getting through expected daily life routines was seen as a responsibility to overcome without pause or questioning. Harriet's extract below also adds to understanding of societal 'good mothering' expectations of mothers as self-sacrificing, whereby the needs of the new-born and family are seen as the priority:

'*So all in all, as does any Mum, you know, you get um, pushed to the bottom of the pile'* (Harriet)

In this regard, some of the women reflected on societal double standards, whereby women recovering from Caesareans are not treated equally to generic post-surgical patients, but as automatically possessing the intrinsic and physical capability to take over household responsibilities straight after surgery:

'*I do find that erm.. It is a major operation really, and I think because you've had your baby straight out of hospital, and you go back to being at home, and kind of having to just get on with things, and maybe if you've that surgery, or a similar surgery but for a different reason, or in that area, or.. I think you would be given a lot more instruction to stay.. you know like immobilise yourself a bit more, don't do as much, erm.. get a lot more help, but I think it's those.. You come*

out and you have to be ‘the Mum’ to the new baby and if you’ve got other children, those children, and your husband goes back to work after a couple of weeks,’ (Charlotte).

As exemplified in Charlotte’s use of the term ‘*the Mum’,* it became apparent from most of the women’s accounts that inability to physically actualise internalised expectations had a significant negative impact. For example, Sarah used the wording ‘*Mum guilt*’ to express her sense of culpability towards her family in not being able to fulfil caregiving tasks to the degree she feels acceptable. Lisa’s extract expands on the sense of guilt she experienced, but also a sense of incongruence to her concept of selfhood:

‘*and it was really hard not to have judgement for yourself, when you want to do your best for this little person that you’ve chosen to bring into the world, and.. and it just.. I know my natural capacity and it’s just been.. so depleted, and still is.. very depleted, um, it’s been a long term haul, you know, er effect*.’ (Lisa)

The next theme will discuss in greater detail how physical healing is synonymised with a synchrony of the different facets of self-concept.

3.2.1.7 Healing as a return to ‘normality’

According to Perun (2013), a new mother has various ‘spheres’ of identity, whereby a healthy transition is achieved when the maternal identity is in balance with pre-existing concepts of self. To this end, women’s narratives disclose how the lifestyle impact of the slow healing wound is incongruent with the women’s sense of self, resulting in feelings of desynchronisation and emotional unbalance. For example, some of the women expressed how their physical mobility and gait became synonymous with an ‘*old lady’*; an image that contrasts with their self-concept as healthy child-bearing women. Additionally, Maura’s contrasting narrative of being a healthcare professional versus person needing prolonged care and Harriet’s use of the phrase ‘*I’m not a crier*’ from the extracts below suggest that some of the women’s positive self-concepts were defied by the challenges brought on by slow recovery:

‘*I think a lot of the time I was able to just get on with it, because I was able to compartmentalise and go - oh, this is happening because of this, I understood the searing pain would be musculature, I was able to problem solve that stuff with myself, um, but I think it was the.. it was the real life consequences, the practicalities, the feeling vulnerable and dependent that.. that.. nothing had prepared me for that at all*. ’ (Maura)

‘*and I remember just cry- and I don’t ever cry, for anything, I’m not a crier, but I was crying on those two occasions going to hospital because I just thought, maybe I’m not, maybe I’m not going to see my children again’* (Harriet)

In this regard, Harriet’s constant description of herself as a *‘tough nut’* and ‘*positive*’ person throughout her interview served to express both how identity confirmation acted as a protective mechanism, but also at times the disparity between her self-image and sense of helplessness and powerlessness:

‘*felt dirty because it was just blood all the time, um, just really down in the dumps, and I think if I.. wasn’t as strong a character as I am, I would have definitely spiralled into postnatal depression,*

um, for sure, because it was just harrowing, um, and very worrying, you know, you just felt very fragile' (Harriet)

Though all the women's wounds had developed scars by the time of interview, indicating granular wound closure, most of the women did not feel that they had fully healed. The women's definition for what fully 'healed' would mean for them held strong resemblances across narratives. There was a general agreement that healing would mean 'feeling' and being able to undertake activities or behaviours that defined who they were before they became mothers. While some of the women acknowledged that bodily changes (i.e. '*hanging*' tummy) was part of the expected CB consequence, it was apparent that some of the women linked unexpected physical changes such as unacceptable scaring and chronic scar pain as the repercussion of abnormal wound healing.

It should be noted that the underlying refrain of body image dissatisfaction was subtle within the women's accounts, with women choosing wording associated with wanting to '*feel*' as opposed to 'look' more like themselves. There could be plausible explanations for this, for example Charlotte's initial apology over sounding '*vain*' suggests consciousness over being judged for appearing to place her own needs first, or worry over something as frivolous as physical appearance despite societal pressures of perfection:

'it sounds a bit vain saying these things, but it is..it's your appearance and your confidence as well, like what you look like in your body'

In this sense, for these women healing meant reverting from the 'changed' self as much as possible back to the 'original' self. For example, Maura described how finally receiving her beautician's approval to have the scar area waxed signified a milestone in terms of healing. Restrictions in clothing as an expression of self, due to prolonged scar pain/sensitivity or poor body image was another key feature in most women's accounts. For example, Lisa reflected how even though she never previously enjoyed wearing restrictive clothing, removal of certain clothing options made her more aware of the division between a pre-Caesarean self and the 'changed' self. Charlotte's extract further summarises women's sense of loss over lifestyle choices that were available to them before the recovery complications:

'*So it does look different in clothes than you want, and it's choosing the different clothes, and like I can't have underwear or trousers at the minute that sit or would sit on that line as it would dig in and it's sore and ermm.. So I think there's that impact that you have with what you look like and what you can wear and how comfortable you are'* (Charlotte).

In terms of regaining a sense of self through resumption of pre-maternal activities, the significance of exercise resounded strongly in a lot of the women's narratives. These women expressed how inability to exercise due to the long-lasting impact of the slow healing wound hindered the process of returning to their previous physical form. Thus, a psychological interaction was evident between inability to exercise and loss of self-concept; expressed by the women through narratives surrounding negative body image and loss of original bodily functions. These women explained how being able to exercise would make them '*feel*' more like themselves and would signify regaining agency over their own bodies:

'*I stared exercising at 5 months, yeah, 5, 6 months more like, and er, that's when I felt more like me*.' (Amanda).

'*ultimately if I want to kind of, get my life back, which is you know, exercise is the way that, that's my only hobby.*' (Harriet)

Women's narratives illustrate how their feelings towards their Caesarean scar residue was complex and multifactorial. The importance women held over what the scar 'looks' like was idiosyncratic, however there was a clear pattern of women's feelings of loss of control over their body due to unwanted and inexplicable scar sensations. In this regard, the majority of women reported how the scar '*twinges*' or '*shoots*' pain unexpectedly, triggered by common bodily reactions such as laughing. These women struggled to put into words the alien-ness of this new part of their body, words such as '*weird*' and '*strange*' were used to describe how the feel of the scar made women hyper aware of the concept of an altered self:

'*the only thing now to do with day-to-day duties is still like if I'm trying to get out of bed with my baby, like lift him up, that's a problem still, I'm conscious of the wound because I can feel it.'* (Amanda)

Some of the women described how they feel differently about their Caesarean scar compared to other scars gained from other types of surgical procedures or accidents, suggesting that wounds and resulting scars harbour emotive value that trigger a psychological response. Charlotte's extract illustrates how the '*feel*' of the scar, described by other women as '*hard*' and like a '*brick underneath the skin'* (Harriet), generates a sense of detachment from their bodies:

'*It is tender, I mean it is seven months down the line, but if you kind of catch it funny it's.. you know it's still not healed properly, or something's not quite right, and it's almost like you know that scar tissue doesn't go away, it's not.. it isn't a case of time heals it, it's always that horrible.. It's that lumpy, hard tissue underneath the scar.*' (Charlotte).

The concept of never-healing due to the perceived permanency of bodily changes was also shared by some of the other women. Two women disclosed how they felt further revision surgery (laparoscopy) would be the only solution in reversing the damage to their bodies and restoring bodily function.

Overall, this theme '*Adjusting to a new normality*' encapsulates how the women negotiated maternal adjustment in light of ongoing physical dysfunction caused by the slow healing wound. For these women, it was a matter of 'surviving' or getting through until some resemblance of normality could be achieved. It is apparent that for the women, 'normality' would be achieved by feeling like a previous self in terms of loss of somatic sensations and a restored ability to perform routines that hold significance to their idiographic concepts of femininity and self.

3.3 Summary of findings

Findings from this study illustrate the symbolic link between Caesareans and the resulting slow-to-heal wounds. The titular quote '*Plan Z and then off the edge of a cliff'* (Lisa) captures the overall essence of the study findings. '*Plan Z*' characterises how the Caesarean birth was a necessity as opposed to a desire for the women interviewed, in which the manifestation of slow healing wounds are primarily *tied to* the subjective Caesarean birth experience as discussed in the first theme. Lisa's description is then followed by the statement '*off the edge of the cliff',* which represents the spiralling sense of loss of autonomy and selfhood as explicated in the themes '*The good mother and the good patient'* and '*Adjusting to a new normality*'. Loss of bodily agency, firstly over birthing options followed by loss of control over slow-to-heal surgical wounds was

apparent in all the women's narratives. What differentiated the women's accounts was subjective expectations and internalisation over what being a 'good mother' entails, as well as the degree of importance women held over maternal constructs that were negotiated during a time of physical and emotional vulnerability. It was apparent that women's early interactions with healthcare staff played a key role in shaping their perceived control over their unexpected postpartum challenges. All the women in this study reported receiving some form of support from significant others despite pandemic restrictions. However the more positive narratives were distinguished by acceptance over loss of independence and reliance on others during a central time in a woman's life, as measured by performance and conformity over societal 'good mothering' standards. Healing from a slow-to-heal Caesarean wound was described by the majority of women as having a chronic long-term impact; these women defined being healed as achieving a sense of normality in the sense of re-establishing family boundaries that were distorted during prolonged recovery and regaining control over life aspects that were previously taken for granted.

4 Discussion

The aim of this study was to explore the experiences of women with slow-to-heal post-surgical Caesarean wounds. Analysis of participants' interviews revealed three overarching themes of *'Tied to that event': healing physical and emotional wounds*; *The 'good mother' and the 'good patient': negotiating being a carer and being cared for,* and '*Adjusting to a new normality'*. Seven interconnecting and over-lapping subordinate themes were manifested from the dataset, which are now discussed further in the context of current literature.

4.1 Superordinate theme 1: 'Tied to that event': healing physical and emotional wounds

One key finding from this study is the strong immersion of women's CB story within narratives of delayed postoperative wound healing. The reciprocal relationship between physical and psychological recovery in the context of a meaningful trigger event is well founded in literature (i.e. Richmond, Thompson, Deatrick & Kauder, 2000). Findings surrounding generic patients' recuperation from traumatic injury suggests that recovery consists of physical and emotional fallout stemming from the life changing accident or event as central to how the patient reconfigures healing (Rosenberg *et al*, 2020; Roesler, Glendon & O'Callaghan, 2013; Richmond, Thompson, Deatrick & Kauder, 2000). Congruently, qualitative analysis of text components of survey responses from 2,960 women that had a CB in 2006 generated a key theme of '*Wounds and hurt feelings'* (Redshaw & Hockley, 2010). Findings are analogous to the current theme '*Tied to that event'*, in portraying how physical wounds resulting from the CB procedure represented women's emotional fragility which was tightly linked to birth disappointment.

In this regard, there is strong evidence that how women appraise their births can significantly shape the overall postpartum experience, and vice versa (Falk, Nelson & Blomberg, 2019; Crookal, Fowler, Wood & Slade, 2018). There is recognition that a satisfying birth can be empowering and self-affirming, which in turn can promote sense of closure over a previous traumatic birth and increase self-advocacy in care involvement (Nieuwenhuijze & Leahy-Warren, 2019). Conversely, debate surrounding birth dissatisfaction has moved away from choice of birth mode towards the disempowerment of women during birth, which has been linked to impaired mother-infant bonding, loss of maternal self-esteem and decreased confidence in dealing with postpartum

challenges such as slow-to-heal wounds (Tomsis *et al*, 2021). These findings complement Downe *et al*'s (2020) proposal of childbirth as a '*complex salutogenic phenomenon'*. The theory of salutogenesis was conceptualised in the 1970's and lends to the philosophy of health as being influenced by an individual's sense of coherence or the degree they perceive an adverse situation as manageable and comprehensive to their personal values, attributes and standing in society (Antonovsky, 1979 in Mittlemark & Bauer, 2017). This complements the biopsychosocial understanding of birth and postoperative recovery as an amalgamation of competing and interlinking social, cognitive and emotive factors (Engel, 1977). Indeed, a scoping review indicates that strong maternal sense of coherence is related to lower chances of needing surgical birth and improved postnatal outcomes in general (i.e. lowered likelihood of post-traumatic stress symptoms; Ferguson, Davis, Browne & Taylor, 2022). Whereas findings from Rosenberg *et al's* (2020) study exploring patient experience of traumatic injury suggest that successful recovery was impingent on ability to sustain a coherent sense of self following lifechanging alterations to bodily image and function. Furthermore, this study also found that the traumatic event which led to injury threatened patients' self-concept and understanding of their lived world in some cases.

Taken together, these findings lend perspective to the overarching theme '*Tied to that event*' in that women's internalisation over the degree to which their CB compromised their self-identity as a new mother contributed towards their sense of resilience in coping with the real-life impact of slow healing wounds. In this sense, the subtheme '*Regaining control over an unpredictable body*' depicts the women's lack of coherence over physical selves that were no longer manageable or recognisable, further accentuating loss of ownership over bodies that became clinical property during birth. Existing wound studies can shed light on the link between surgery and bodily coherence; for example, studies exploring the impact of complex postsurgical wounds demonstrate the intensity of negative emotions participants felt in seeing the wounds and experiencing severe and unexpected symptomology for the first time (Pađen, Griffiths & Cullum, 2022; Chen *et al*, 2020; Tanner *et al*, 2012; Fuentes-Ramírez, 2017; Andersson *et al,* 2010). In their research exploring patient experience of open thoracic drainage wounds, Chen *et al* (2020) used the term '*emotional stress response'* to describe the psychological saliency of discovering wounds that are already perceived as deforming and threatening from the outset. Congruent to findings from the current theme, participants in these studies use rich metaphorical language to emphasise how '*horror stories*' (Tanner *et al*, 2012) or vivid flashbacks concerning sensory reactivity to distressing wound appearance and sensations (i.e. extreme pain, smell, etc; Andersson *et al*, 2010), became a distinguishing aspect of participants' subjective recovery narrative - lending to the concept of physical and psychological scarring from traumatic injury. In addition, a meta synthesis of eight qualitative studies surrounding patient experiences of living with malignant wounds highlighted how uncontrollable wound symptomology, such as prolonged exudate and pain, exacerbated an overall sense of loss of agency and triggered unhelpful coping mechanisms that perpetuated negative affect, such feelings of self-isolation (Mansourzadeh, Mehri, Nir & Zendehdel, 2016). Similar to most of the women interviewed, participants from these wound studies reported how continuous side-effects intensified a sense of despair as they struggled to contain, understand and predict complex wound healing prognosis.

As touched on previously, there were individual differences in women's narratives surrounding embodiment of the wound, relating to the transcendence of the physical wounds into a psychosomatic sense of self. In their article, McCaughan *et al* (2018) rationalised that pre-surgical information on what to expect buffered against patients' initial shock of realising an open surgical

wound, hence explaining why participants who underwent elective surgery in their study seemingly adapted better compared those who needed emergency procedures. In contrast, the women's narratives of living with slow-to-heal CB wounds contribute towards the ongoing debate against nomenclature of whether the Caesarean procedure was planned or not. In the current study, three out of the eight participants would be categorised as having had a planned, repeat CB. Yet there were stark contrasts between these women's accounts of the surgical birth procedure and postpartum expectations versus reality of their situations. For example, Sarah's account highlighted how her planned Caesarean was not the calm and controlled birth she had hoped for following a previous traumatic birth, which transgressed into loss of agency over the resulting postoperative wound that also failed to heal in a timely fashion. In contrast, although Tina's repeat CB experience was also not straightforward due to obtaining a suspected SSI shortly after birth, her narrative was dominated by nuances of acceptance over her slower to heal wound.

On this note, there are parallels across both generic outpatient and maternity research findings; in that both groups are evidenced to hold expectations or beliefs over how they would heal or what life would be like following the trigger event - be it surgery or birth. In this regard, divergences from expectations (including anticipated wound healing), contribute towards negative affect such as loss of morale, feelings of disempowerment and anxiety (i.e. Pinto *et al*, 2016; Allvin, Berg, Idvall & Nilsson, 2007). For the same reason, new mothers' experiences of complex wound healing diverges from other groups with similar wound aetiology due to the unique significance of postpartum expectations as captured in the subtheme '*How things "should" have been'*.

It is well regarded that most women possess authoritative knowledge or an internalised script about what the postnatal period should be like, which does not necessarily correlate to common clinical recovery indices (i.e. prolonged pain; Wardrop & Popadiuk, 2013). Arguably, most of the participants in this study will be influenced by White, middle class centric views of early motherhood as a symbolic time of patience and endurance, wherein new mothers are expected to embrace their newfound role in undertaking novel duties and responsibilities (Boyd, 2022). This means women with slow-to-heal CB wounds are faced with the added challenge of overcoming (or appearing to overcome) physical and psychosocial injury in order to adhere to societal 'good mothering' mandates. Overall, women's narratives suggest that the physicality of slow-to-heal CB wounds embodies the emotional anguish caused by loss of postpartum expectations. This corroborates existing findings in the literature stipulating that loss of a highly anticipated, socially defining period reduces self-efficacy during a time when women are already rendered more vulnerable due to significant hormonal and lifestyle changes (i.e. sleep disruptions; Quinlan, 2019).

In relation to this, the subtheme '*How things "could" have been*' captures women's attempts to re-trace their decision-making steps and comprehend how they managed to arrive at their current unexpected situation. Narratives of blame were dominant throughout women's accounts; with sense of blame being directed inwardly (i.e. not possessing childbearing physiology) or externally towards the healthcare system. Leventhal et al's Common Sense Model (1996;1997) can lend perspective on this; in their qualitative study Gehring *et al* (2020) maintain that pre-surgical patients form expectations surrounding the length and experiences of healing based on internal scripts they coined the 'Self as Anchor'. According to their findings, mental models of healing perception complement the 5 interactive constructs of illness representation, in addition to themes of *outlook,* or relationship/ attitudes towards healthcare providers and *motivations* for

recovery, as internal (i.e. self efficacy) or outward facing (i.e. for the benefit of others). Harmful illness cognitions are triggered when there is an unacceptable psychological distance between the patients' current state as determined by perceived loss of control over symptoms and their subjective 'Self as Anchor', leading to feelings of chronicity or 'non healing' as implied by the women in this current study.

The theory of salutogenesis also provides further explanation, in that insufficient information and knowledge surrounding an adverse situation leads to increased rumination, which can be expressed through discourses of blame as women strive to understand and create a sense of meaning from their distress (Furuta, Sandall, Bick , 2014; Carlgren & Berg, 2008). On this note, a mixed methods systematic review including thirty-four articles surrounding lived experience of childbirth-related perineal injury found that women's narratives of blame are positioned within the context of loss of situational and bodily control (Shorey & Ng, 2020). This serves to enclose psychoneuroimmunology theories surrounding the interactive relationship between negative affect and slow healing wounds (i.e. Lutgendorf & Costanzo, 2003). Thereupon, sustained adversity following a traumatic event (CB) can maintain maladaptive biological, psychological (i.e. intrusive thoughts) and behavioural (i.e. avoidance) responses which can impair the wound healing process further.

Theme summary and implications

The overarching theme ''*Tied to that event": healing physical and emotional wounds*' adds to understanding of the inter-connectedness between the CB experience and slow-to-heal post-operative wounds. The centrality of a traumatic event on recovery is well documented (i.e. Richmond, Thompson, Deatrick & Kauder, 2000); this study contributes to knowledge regarding CBs as a unique transformative event which determines how women embed slow-to-heal wounds into a coherent self-narrative. The centrality of the connection between physical and emotional healing has important implications in terms of women's clinical needs assessments. For example, it is estimated that 7% of postnatal women suffer from posttraumatic stress disorder (PTSD) as defined by DSM-V (American Psychiatric Association, 2013), in comparison to 24%-34% of postnatal women that report post-traumatic stress (PTS) symptoms (Tham, Christensson & Ryding, 2007). Qualitative studies are arguably in a stronger position to aid understanding of women's emotions that may not necessarily fall within diagnostic criterions (i.e. anger), and therefore become 'invisible' in research (Lobel & Ibrahim, 2018., Graham, Lobel & DeLuca, 2002). Findings suggest a balanced approach in care is necessitated, to ensure women's emotional responses to complex postnatal healing are not pathologized or labelled, but equally are not normalised or undermined.

Additionally, the subtheme '*How things "should" have been*' summarises dissonance between the reality and expectations of the birth and postnatal period as having emotive significance in how slow healing wounds are internalised. This points to a need for further research on how information should be packaged and disseminated to expecting families in order to prepare them sufficiently for all birth-related eventualities. This is an important area for consideration, as women that have felt that they have participated in their childbirth as an informed choice indicate improved postpartum adjustment (Thirukumar, Coates & Henry, 2021). However, achieving the right balance of information can be challenging; on the one hand, positive expectations of the postpartum period is evidenced to act as a protective factor during pregnancy (Harwood, McLean & Durkin, 2007). Furthermore, receiving too much information over an uncontrollable situation

can be contraindicative and cause undue psychological harm (Furuta, Sandall & Bick, 2014). On the other hand, discordance between preconceived expectation and reality can disrupt maternal adjustment, resulting in loss of self-esteem required in building resilience towards challenges such as complex wounds (Albanese, Geller, Steinkamp & Barkin, 2020; Harwood, McLean & Durkin, 2007). Moreover, Razurel *et al* (2011) maintains that antenatal preparation may not adequately prepare women for the realities of the postpartum period due to the psychological distance between pregnancy and motherhood, meaning women may not absorb information efficiently. Accordingly, some of the women in this study explicitly admitted to not paying attention to CB related information as they had planned for a vaginal birth.

Overall, the current study findings complement existing research pinpointing gaps surrounding communication and information provision for women at risk of, or already living with, CB related morbidity (i.e. Weckesser *et al*, 2019). These emerging issues will be considered further in the remainder of this chapter.

4.2 Superordinate theme 2: The 'good mother' and the 'good patient': negotiating being a carer and being cared for

Positive social support is a recognised key element underlying successful life transitions, be it motherhood (Taubman-Ben-Ari, Navon & Davidi, 2021; McLeish, Harvey, Redshaw& Alderdice, 2021; Briscoe, Lavender& McGowan, 2016) or return to wellness following injury and illness (Lindsay *et al*, 2017; Mavros *et al*, 2011). Studies demonstrate how feeling valued and verified by others contribute towards a sense of coherence in managing unchartered territories (Taubman-Ben-Ari, Navon & Davidi, 2021; McLeish, Harvey, Redshaw & Alderdice, 2021; Tham, Ryding & Christensson, 2010). However, the wider picture is more complex; for example, mobilising support via help-seeking can be challenging for those that are already in a disempowered position (Shorey & Ng, 2020). In this regard, the women's narratives demonstrate the internal conflict associated with the pressure of fulfilling caring duties within the household, juxtaposed with the experience of requiring ongoing care due to disability resulting from poor postoperative wound healing. Interviews uncovered covert yet presiding narratives associated with regaining status quo that had become distorted, both within the household as the primary mother figure and as a consumer of the healthcare system.

Regarding the latter, patient-clinician relationship or communication with healthcare staff has important implications in postnatal adjustment (McLeish, Harvey, Redshaw & Alderdice, 2021; Darmody, Bradshaw & Atkinson, 2020; Walker, Rossi & Sander, 2019; Briscoe, Lavender & McGowan, 2016). The relationship between woman and midwife in particular transcends other types of professional relationships in healthcare settings, with authors such as Reed, Rowe and Barnes (2016) describing this as a '*ritual companionship'* based on mutual trust of the birthing process as a balance between rational and nonrational (i.e. intuition; Parratt & Fahy, 2008) '*brinkmanship*' (reading of the other's inner thoughts and body language in order to inform partnership; Thompson, 2010). Studies articulate how quality of this relationship mediates women's sense of agency over CB, even in emergency scenarios, and in essence satisfaction with the overall birth experience leading to physical and psychological outcomes (Ayers, Bond, Bertullies & Wijma, 2016; Ayers, Radoš, Balouch, 2015). Despite this, the sub-theme '*The invisible postnatal mum'* corresponds to research findings surrounding lack of postoperative follow-up following CBs (i.e. Djatmika, Lusher, Meyrick, Byron-Daniels, 2021; Weiss, Fawcett & Aber, 2009). In some cases, the women in this study blamed lack of continuity of care as the underlying reason

for preventable worsening of CB wounds, whilst others described navigating care pathways that did not seem to correspond or flex to their additional needs. Similar to other qualitative research surrounding post-Caesarean healthcare treatment (i.e. Puia, 2018; van Griensven, Moore & Hall, 2016), the women interviewed expressed a sense of abandonment and puzzlement as they pondered on why their emotional and physical complaints were not taken seriously by healthcare staff, with interactions characterised by staff being apathetic and seemingly uninterested in the real-life impact of delayed wound recovery. An American study involving separate focus groups with new mothers and clinicians sheds light on this; their findings indicated a dissonance between what women expect of staff, and what healthcare professionals believe their roles are in preparing women for the postpartum period. The focus groups with healthcare staff uncovered attitudinal and systemic barriers such as not having the time and resource to manage women's' 'unrealistic' expectations, as well as lack of skills in being able to deal with psychosocial aspects of birth and recovery (Martin, Horowitz, Balbierz & Howell, 2014). Similarly, Childs *et al* (2020) states that most midwifery staff are not formally trained to identify and triage suspected birth-related wound complications.

The discord between needs of patients with complex wounds and what clinicians perceive as treatment priorities are also reflected in other studies. For example, McCaughan's (2018) interviews with patients living with post-operative wounds healing by secondary intention (wound left open to heal) revealed biopsychosocial themes familiar to the current study findings. The second arm of their study explored the views of clinicians caring for these patients. In contrast to their previous study, healthcare staff attitudes were predominantly of a biomedical persuasion (i.e. wound therapy options), with a heavy emphasis on treating clinical symptoms (McCaughan, 2020). Healthcare staff's disregard of patients' self-report of latent symptoms such as pain, and narrow focus on physical wound markers is further exemplified in Stegwee *et al's* (2020) study involving post CB women in Holland. This qualitative study conveyed participants' frustration at receiving a late diagnosis of having a niche in uterus caused by abnormal tissue healing following a CB, due to healthcare staff dismissing women's symptoms (i.e. pain and abnormal menstruation) as '*normal*'. There are parallels across both this Dutch study and the current research findings in how the women were overtly excluded in medicinal territory concerning their bodies following a CB.

To this end, some authors posit that post-surgical complications such as SSIs challenge the fabric of medicinal proficiency and cause disequilibrium in the patient-clinician dynamic. Medical staff attempt to maintain the upper hand by placing the onus of blame and responsibility back to the patient, whilst still maintaining ownership over medical decision-making. On this note, social research illuminates how 'good patient' ideals are subliminally enforced during patient-clinician interactions (Tanner *et al*, 2013; Gardner & Cook, 2004). For example, Gardner and Cook (2004) propose healthcare staff maintain a professional distance in the self-proclaimed best interest of protecting patient emotional integrity. True to this observation, the narrative of the 'hysterical woman' was apprehensible in some of the women's accounts from the current study (i.e. staff '*eye-rolling'*). A process of 'brinkmanship' is indicated by these women's reports of trying to decipher healthcare staff surreptitious attitudes and signals. For example, some of the interviewees tried to make sense of staff apprehension by speculating that they tried to conceal incompetency in dealing with wound aetiology that went beyond '*textbook*' provisions, resulting in women feeling further marginalised and helpless.

For the most part, women struggled to make their intuitions or bodily knowledge that their Caesarean wounds did not feel ‘*quite right*’ heard over clinical insularity. Other authors maintain that the Caesarean procedure is a disregard of birth as an ‘embodied knowledge’, with birth trauma stemming from women’s cognitive dissonance in going against visceral biological signals during childbirth or loss of intrinsic sense of childbirth as a ‘one-ness’ with the body (Reed, Sharman & Inglis, 2017; Munro, Kornelsen & Hutton, 2009). In this sense, the sub-theme ‘”*invisible” postnatal Mums*’ contributes towards current understanding of negative births, in that continued healthcare staff dismissal of women’s instinctual concerns surrounding postoperative wounds can sustain legacies of disempowerment, as well as loss of agency and trust in one’s own body. These thematic findings expand current knowledge of postoperative CB needs in that there was a sense that most women in this study conceptualised healthcare staff disinterest in their wounds as being placed within societal views of CB as a lifestyle choice synonymous with laziness and selfishness. This concurs with MacKay’s (2021) findings that women are deemed culpable for socially defined consequences of neglecting ‘good mothering’ duties due to maternal lifestyle ‘choices’ (i.e. childhood obesity linked to non-breastfeeding), further entrenching notions of shame and failure. On the other hand, this study adds to a plethora of research confirming that patient satisfaction can be achieved by mindful, woman-centred approaches based on the concept of humanistic authenticity (Hopkins, 2004). For example, responding with simple re-affirming gestures such as touching and acknowledging feelings.

The sub-theme ‘*Mothering the Mother*’ likewise conveys the complex emotions women face in relinquishing control over significant household domains, during a time when successful transition to motherhood is characterised by the establishment of traditional caring roles and duties. All the women in this study reported a sense of gratitude that they were able to gain practical family support while they were physically encumbered with slow healing wounds. However, degree of acceptance over prolonged dependency and household role reversals varied within and across accounts. This variance can be explained using Role Satisfaction theory, which postulates that value and meaning ascribed to gendered roles within the household drives acceptance (or lack thereof) when ability to fulfil these duties is impaired (Cowan & Cowan, 1988). For example, a qualitative study exploring Chinese-Singaporean housewives with upper limb restrictions found that emotional adjustment was related to symbolism ascribed to housework as a representation of women’s status and ‘being’ (Cheung, Clemson, O'Loughlin& Shuttleworth, 2016).

Moreover, a literature review summarised how prolonged recovery from injury or illness resulted in feelings of displacement, with the resulting changes to family dynamics creating wider ripple-effects that can go beyond the main carer-patient relationship focus that prevails in studies (Pittman, 2003). This review employed Family Stress theory to explain findings (Patterson & Garwick, 1994; Reiss, Steinglass & Howe, 1993); in that family membranes are restructured in accordance to meaning ascribed to adversity, particularly if perceived to have chronic repercussions to dynamics (i.e. disability caused by slow-to-heal wounds). In accordance with these findings, the women interviewed in this study recounted lasting feelings of failure and guilt in not being able to resume household responsibilities for a prolonged period. These narratives of ‘*Mum guilt’* were particularly deep seated in women’s recollections of having to resign primary care-giving responsibility over their children during recovery. ‘Mum guilt’ is a relatively new phenomena mainly used to describe the internal conflict between the ‘actual self’ and ‘idealised self’ experienced by working mothers in having to compromise traditional stay at home ‘intense mothering’ standards advocated by society (Sullivan, 2015). Similarly, studies on parents of

premature babies in ICU also illustrate how perceptions of lack of agency and helplessness can contribute towards new mothers feeling guilt (Collum, 2021). A study on early parental interaction following a CB likewise allows deeper comprehension of how continued role reversal can threaten motherhood identities. Similar to the women interviewed in the current study, the mothers from Ayala *et al's* (2015) article articulated beliefs regarding gender equality in infant care. The women reported feelings of warmth as fathers bonded with their infants while they recuperated and received clinical attention following their CB delivery. However, the authors suggested that satisfaction was fulfilled when infants were returned to their mother for nurturing as part of an unspoken familial role script.

These findings can be applied to explain the current study sub-theme '*Mothering the Mother*' in greater depth. It can be rationalised that sense of failure over not being able to complete defining roles within the family for a prolonged period can foster a sense of permanency to meaningful situational changes, further accentuating loss of self-coherence and feelings of despair (Shorey & Ng, 2020; Monsen, Acosta & Kumlien, 2017). However, it is important to note that positive narratives of being cared for were also relayed by the women in this study, with women such as Tina and Maura reflecting how this experience had strengthened their familial relationships. On this note, a supportive network is evidenced to promote resilience and posttraumatic growth by enabling alternative perspectives, enhancing problem-solving skills (Taubman-Ben-Ari, Navon, & Davidi, 2021), and providing an outlet for emotional disclosure which is evidenced to ameliorate wound healing (Weinman *et al,* 2007).

To conclude this sub-theme, it is not simply availability or quality of social support that determines postoperative adjustment to slow healing wounds as implied by positivist literature on the subject (Srisopa & Lucas, 2021; Alexander, 2013; Broadbent & Koschwanez, 2012). Indeed, receiving unbalanced or unwanted support can have the opposite effect, creating feelings of role insecurity and exacerbate loss of agency in new mothers (Choi, Henshaw, Baker & Tree, 2005). Qualitative studies such as the current, illuminate that the experience of receiving social support is multifaceted, particularly in population groups (i.e. postpartum women) that are heavily guided by societal mandates surrounding gender roles. Rather, it appears that social support may improve recovery outcomes if perceived as enabling and giving back a sense of control and power during moment-to-moment interactions.

Theme summary and implications

For the most part, there was a sense of maladjustment as women recounted negotiating and re-establishing power boundaries that became disordered during a time of vulnerability. Women sought information and reassurance from healthcare professionals in their attempts to re-gain control of a malfunctioning body. However, it is apparent that the paternalistic power dynamics prevalent during the CB were still prevailing during interactions with staff over wound care. This resulted in women interviewed feeling further disempowered, alienated and less able to frame their CB experience positively. Women's gendered identity formulation was also prevalent in narratives surrounding prolonged loss of normative mothering roles in the household. It was explicitly mentioned by some of the participants in this study that they went through a period of grief as they struggled to accept loss. This sense of loss was multicomponent and related to loss of an idealised self, and a permanent loss of a postpartum fantasy for some of the participants as they contemplated how they are more likely to need a repeat CB and go through similar issues. Bueno (2022) explicates that society affixes hierarchy to grief, with less tangible losses (i.e.

miscarriage) being less likely to be acknowledged or recognised; this may also contribute towards the 'invisibility' status of women living with postpartum morbidities. Nevertheless, sensitivity to other's responses is particularly heightened during times of vulnerability (Bueno, 2022). In this regard, women's narratives supplement proposition that healthcare staff interactions form emotive 'hotspots' in the birth story schema (Ayers, Bond, Bertullies & Wijma, 2016).

On another note, authors such as Kurz, Davis and Browne (2021) propose that postpartum vulnerability is unavoidable as women attempt to reconfigure a fragmented self following pregnancy and childbirth. However, these moments of vulnerability can signify a transformative turning point if met by positive connections with others that harness developmental growth via enabling women's 'intrinsic power' or inner sense of knowing and trust in one's body. Delivery of this 'empowering practice' as coined by Parratt (2010), is conditional on caregivers' mindfulness and ability to relate to women on a more inherent level. By contrast, The UK Work, Health and Emotional Lives of Midwives (WHELM, 2018) study reports that midwifery staff face wider organisational challenges such as bullying in the workplace and burnout leading to 'compassion fatigue' (Svanberg, 2019). Therefore, it is arguably not enough to simply suggest staff training in domains surrounding women's emotional health as a solution, given the potential lack of staff capacity to deliver. With the NHS becoming even more burdened (Department of Health & Social Care, 2021), further thought is needed into upskilling and development programmes for staff that are realistic and sustainable (Baxter & Lymn, 2015; Nobbs & Crozier, 2011).

Lastly, this study complements existing findings suggesting that social support can inadvertently be maladaptive to postoperative patients (Pađen , Griffiths & Cullum, 2022), and new mothers' psychosocial adjustment (Choi *et al*, 2005). For example, some of the women interviewed reported contradictory feelings of needing support whilst feeling resentful of having others take over their primary caregiver responsibilities. These results have important connotations in the context of wider recommendations for the mobilisation of networks to provide practical support during the postpartum period (Albanese, Geller, Steinkamp & Barkin, 2020; Slomian *et al*, 2017).

This study illuminates how women's needs vary widely, and for some, consigning mothering responsibilities can be disempowering and exacerbate trauma relating to loss of control. The next theme will discuss the impact of slow-to-heal wounds on women's maternal role-attainment and identity negotiation.

4.3 Superordinate theme 3: Adjusting to a new normality

The theme concept of '*Adjusting to a new normality'* is a key finding in many other studies, from both wound healing and childbirth literature spheres. For example, studies on women's birth experiences adds understanding to the concept of 'normality'- whether this is attaining a 'normal' birth or adapting to a 'new normal' following childbirth, as pertinent to some women (Finlayson, Crossland, Bonet & Downe, 2020; Dudley, Kettle , Waterfield & Ismail, 2017; Fenwick, Holloway & Alexander, 2009). Similarly, acceptance of a new 'normal' including accomplishment of daily routines and regaining of pre-surgical bodily function is identified as a key factor underlying psychological adjustment in a plethora of wound healing studies (McCaughan *et al*, 2018; Fearns, Heller-Murphy, Kelly & Harbour*,* 2017; Grey, Enoch & Harding, 2006). For example, analysis of one-to-one interviews with ten participants living with open surgical wounds resulted in one overarching theme of '*Negotiating a new normality'* (Pađen, Griffiths & Cullum, 2022). There are key similarities to the current theme *'Adjusting to a new normality'* in terms of the complexity of

patients' experiences in adapting to the uncertainty and chronicity of an injured self. However, there are also notable dichotomies surrounding the maternal and feminine self as assemblies of a 'new normality' following a CB. This separates the current study theme from findings derived from generic complex wound studies, and findings surrounding wounds derived from assisted vaginal births (i.e. anal sphincter injury; Darmody, Bradshaw & Atkinson, 2020; Crookall, Fowler, Wood & Slade, 2018)

For the most part, studies describe returning to normality after birth or injury as a journey towards acceptance (Huber, Tunón & Lindqvist, 2022); the word 'journey' suggesting a process of discovery, with a clear start and end point. Contrastingly, the participants in the current study largely described their recovery from slow healing CB wounds using rich emotive descriptors synonymous with survival and conflict associated with the 'fight' in re-gaining control. The sense of precariousness associated with the word 'new' is synonymous with motherhood. For example, in their article, Upton and Han (2003) suggests that the term 'new mother' in itself implies an irreversible change of identity once a baby is born. Moreover, other authors such as Mercer (2004) propose that the transition to motherhood is characterised by 'griefwork' as new mothers replace multiple 'losses' with other identities that are deemed more suitable to their new position in society. Indeed, this theme '*Adjusting to a new normality*' elaborates on previous findings in that new mothers have expected timelines in which 'normality' or a sense of settlement into one's place as a new mother would be attained following birth. For example, The NHS UK website (2022) states that post-Caesarean women can recommence daily activities after '*6 weeks or so*', suggesting a return to baseline at six weeks postpartum despite evidence that this marker is unrealistic for most women, particularly those with assisted births (Sultan & Carvalho, 2021; Borders, 2006). It was notable that women from this current study and from other qualitative investigations use the six weeks' timeline as a benchmark, with lack of anticipated functionality or 'normality' following this marker resulting in negative emotions, feelings of failure and perceiving CB wounds as non-healing (i.e. Coates, Thirukumar & Henry, 2019; Crookall, Fowler, Wood & Slade, 2018). This finding again indicates misalignment between clinical priorities and assessments versus patient expectations.

Furthermore, literature on the subject describes maternal identity as the end product of 'maternal role-taking' or sense of acceptance and compatibility in the woman's new position within her household (Mercer, 2004; 2006). Scholarships on maternal identity formation concur that psychological vulnerability ensues when the woman's actual self is misaligned with the woman's idealised self, or self-concept shaped by the woman's own expectations which are turn is shaped by culture specific 'good mothering' ideologies (Laney, Hall, Anderson & Willingham,2015; Mercer, 2004).

In concurrence with this, women's narratives illuminate how the concept of returning to 'normality' is multifaceted, and based on a pre-defined subjective baseline (i.e. pre-pregnancy state, previous postpartum experience) integrated with women's perceptions of what society would consider standard maternalistic achievements. As an example of the latter, the women in this study expressed feeling further ostracised by their prolonged inability to fulfil behaviours representative of motherhood, i.e. handle baby apparatus such as prams due to wound related bodily restrictions. Interview narratives indicated how extended inability in mastering these 'taken for granted' tasks served as a stark reminder to the women that they are outsiders in motherhood realms, resulting in a sense of continuous failure.

The sub-theme ‘*Living in “Survival Mode*”’ captures the sense that postpartum was a period of mental and physical endurance embodied by slow-healing wounds, in contrast to a highly anticipated transitional event marked by quality time with a new family unit. The essence of this sub-theme *‘Living in ‘Survival Mode’* was characterised by the women tolerating a ‘less-than’ self. For many of the women, this transient identity was unrecognisable to their previous feminine or professional identities as capable women. In this regard, this study adds to comprehension of how women’s attempts to acclimatise to motherhood is disrupted by the negotiation of illness identities associated with hard-to-heal wounds, which does not cohere with stereotypes analogous with ‘good mothering’ schemas. As previously discussed, women reported feeling minimised by healthcare staff that were perceived as representing societal ‘good mothering’ vindications of women that have given birth via Caesarean. Interestingly, despite women’s awareness of societal double standards, their narratives revealed how they self-enforced ‘good mother’ and ‘good patient’ imperatives of self-sacrifice and suffering silently for the greater good of their family and others involved in their care. This finding can be contextualised by Curren *et al’s* (2022) explanation. According to the authors, new mothers gain a sense of rite of passage in being able to ‘*power through*’ duties while facing postnatal challenges such as tiredness and stress. On this note, other authors have highlighted how discourses surrounding womanhood, coined ‘superwoman’ by Malatzky (2011) to describe an idealised image of women who can ‘juggle’ multiple societal demands such as work and mothering, can act as a protective mechanism in certain instances. For example, findings from Edge and Rogers’ (2005) research on how Black Caribbean women conceptualise postnatal depression, found that adverse events during the postpartum period were constructed though the social filter of a ‘Strong-Black-Woman’ identity. Similarly, some of the women in this study reflected how positive self-concepts congruent with the ‘superwoman’ identity were challenged during prolonged disability and seemingly transformed into a new ‘survivor’- type identity. This finding fits within the description of maternal transition as a non-linear passage, wherein to fulfil their full-potential, women must go through an allegorical period of being fragmented and put back together (Huber, Tunón. & Lindqvist, 2022).

Cognizant with this, Crookall *et al* (2022) propose that maternal self-efficacy is gained not only by the ability to fulfil tasks perceived as intrinsic to sense of selfhood, but also degree of perceived mastery and control over the task at hand. Current study findings strengthen the proposition that personal growth following childbirth is conditional on actualisation of positive self-identities (i.e. independent women), which is contingent on being able to manage and assign meaning to situations necessitating change, such as living with hard-to-heal wounds. It could be that for some of the women in this study, maternal role attainment failure and inability to regain control of bodily boundaries following their CB became internalised as part of a negative birth story, which is further linked to persistent feelings of maternal shame and guilt in other studies (i.e. Jackson, De Pascalis, Harrold & Fallon, 2021; Lobel & Ibrahim, 2018).

Finally, the sub-theme ‘*Healing as a return to ‘normality’’* captures the complexity of the concept of physical healing from the perspective of postpartum CB mothers with slow healing wounds. For example, an interesting finding from this study was the significance of being able to recommence previous exercise routines as a proxy for healing for some of the women. Participants’ narratives illustrated how the role of exercise was two-fold: as a method to regain a previous body, thus indicating rejection of a body that had become altered due to pregnancy and poor post-surgical healing, and as a way to reduce dissonance between their actual self (i.e. incapacitated) and a

previous self-identity (i.e. able bodied). Authors such as Upton and Han (2003) offer further perspective on this; women lose ownership over bodies that become functional vessels subject to public and clinical scrutiny as pregnancies become more visible. The rise in popularity of modern jargon such as 'yummy mummy' mirrors Western society's pre-occupation with post pregnancy physical return to a sexually viable standard, juxtaposed with 'good mothering' subscriptions of selflessness despite body transformation requiring significant time and dedication (Prinds, Nikolajsen & Folmann, 2020; Malatzky, 2017). Though these discourses are mostly associated with post pregnancy weight loss, there is a refined depth of meaning which echoes rigid societal expectations; in that a new mother should appear all '*pulled together'* (Sharon in Upton & Han, 2003, p.683) and therefore in control of her self-image and situation. Furthermore, discourse surrounding 'getting the body back' further affirms the notion that women's bodies are 'lost' during pregnancy and implies that an inability to '*reclaim the body'* is a character failure on the part of the woman (Upton & Han, 2003). In this regard, the widely used term 'letting go of oneself', which describes inability to return to an acceptable pre-pregnancy physical state, seemingly suggests visibility of loss of control; this would have significant implications for women with postpartum wound healing issues. On this note, an analysis study of Australian women's magazines illustrates that the sentiments surrounding the wording '*bouncing back '* to a pre-pregnancy body holds similarities to descriptions surrounding recovery from illness (Roth, Homer & Fenwick, 2012). Importantly, MacKay's (2021) review of local and national health campaigns indicated that the aforementioned jargon is widely found in health promotional material aimed at new mothers. Thus, women are ironically 'empowered' to adapt healthy postpartum behaviours by internalising harmful stereotypes which engender societal 'good mother/wife' mandates (i.e. breastfeeding to lose weight; MacKay, 2021). Worryingly, these imperatives designed to pigeon-hole women are seemingly deeply entrenched and considered benign or even desirable.

Put together, these findings add context to the Gestalt of women that are attempting to recuperate physically from slow- healing post-operative wounds while also negotiating subliminal messages regarding acceptable postpartum body image and behaviour. These thematic findings add to the body of knowledge signifying that new mothers are faced with the ubiquitous task of negotiating multiple and often contradictory societal 'good mother' versus 'superwoman' expectations. As exemplified, women's bodies become 'invisible' following childbirth, yet in order to gain visibility and approval, women should strive for bodies that are unmarked by childbirth (Malatzky, 2017, 2011.;Upton & Han, 2003). It can be rationalised that these pressures are amplified in post-Caesarean women with complex healing who are already self-perceiving as failing motherhood mandates at various levels.

The interconnectivity between body image and self-coherence is not a novel finding; for example, a thematic analysis of Danish women's perceptions of their postpartum physiques were represented within separate 'individual', 'social' and 'political' embodiments (Prinds, Nikolajsen, Folmann, 2020). Similarly, Upton and Han (2003) coined the term 'multiplicity of bodies' to propose the body as a private entity, while also simultaneously an expression of one's positioning and being in the lived world. Using women's narrative from this study as an example, inability to wear previous clothing due to scar hyperalgesia or shame in displaying the scar area was likewise integrated in women's individual accounts of selfhood attainment. For Harriet not feeling the same in lingerie signified a loss of a previous self, whilst for Lisa clothing restrictions manifested a sense of continuation of loss of choice stemming from her CB.

Other studies also indicate how scars function as a chronic reminder of a traumatic experience and symbolise loss of selfhood, with emotional adjustment from physical scaring being contingent on negotiation of a new and acceptable self-identity (Pađen, Griffiths & Cullum, 2022). Consequently, some of the women expressed how ‘normality’ will be achieved once they undergo scar revision surgery. This is similar to findings from other studies surrounding body image and femininity following traumatic surgery. For example authors such as Sunaga and Tamae (2008) uncover the meaning of breast reconstruction as an opportunity for post-mastectomy women to become closer to a previous self, in terms of image and feminine identity, and enable closure over a challenging period in their lives.

Additionally, narratives from the current study disclose women’s sense of the scar area as a separate entity that felt and functioned differently from the rest of their body. For most of the women, this loss of control over the wound site as a representation of surgical birth was experienced during the onset of inexplicable wound pain. Though narratives reveal how severity of pain intensity subsides over time, there was a sense that persistent scar sensitivity triggered continual awareness of loss of bodily boundaries. In this regard, the concept of the fragmented body is consistent across wound and maternity care studies, with the concept of ‘normality’ pertaining to achieving a sense of embodied wholeness (i.e. Pađen, Griffiths & Cullum, 2022). Furthermore, Mackay (2021) notes that images of mothers and mothers-to-be in health promotion material in the UK are largely represented by magnified body areas synonymous with reproduction (i.e. breasts, stomach). On this note, contemporary authors argue for holistic reforming of wound treatment into treatment of the person living with the wound in research (Lusher, 2020; Sen & Roy, 2019).

Theme summary and implication

The superordinate theme ‘*Adjusting to a new normality*’ summarises how persistent disability and symptomology caused by slow-to-heal wounds contributed towards a sense of loss of control and failure manifested during the CB procedure. Narratives revealed how prolonged recovery past a timeline deemed ‘normal’, or women’s inability to foresee an end point to complex healing eroded women’s sense of resilience on a day-by-day basis as indicated by the nuance of the sub-theme *‘Living in survival mode’*. On this note, the term never-ending healing arguably best illustrates the sense that for most of the women, the perceived consequence of poor Caesarean wound healing is life altering. It became apparent that for these women, problematic wounds progressed into problematic scars. Women compartmentalised the scar area of their body as an entity that is unpredictable (i.e. uncontrollable scar sensations) and uncurable. This is similar to findings from the Bluebelle Studies (2017), in that patients with leg ulcers measured healing by subjective notions of how the wound felt (i.e. tightness), suggesting healing as a psychosomatic journey as opposed to a clinically defined destination.

Overall, this theme adds to knowledge of how the multiplicity of competing self-concepts necessary in reconfiguring a new ‘normality’ following complex wound healing is even more pronounced for new mothers navigating competing expectation versus contradictory realities. This theme strengthens evidence pointing to a need for staff psychoeducation to nurture understanding of women’s needs at organisational level, as well as provision of information appropriated to different levels of post CB wound healing complexities. For example, results from this study can be compared to findings indicating clinicians over-estimate women’s satisfaction

with their CB scar appearance, and that psychosocial CB scar-related issues are not taken seriously by healthcare staff (van Griensven, Moore & Hall, 2016).

Lastly, findings highlight the need for interventions focused on redressing sense of ownership in postpartum CB women with slow healing wounds.

The next section will consider in greater depth how these findings can inform future research and practice dedicated to improving the lives of women living with CB wound related challenges.

4.4 Implications for practice in health psychology

This study offers a holistic view of women's experiences of a postpartum that diverges from the norm due to postoperative birth wound complications. To this end, findings indicate that the emotional, practical and informational requirements of the women in this study with additional needs are not being met. Women's narratives surrounding their experiences are multidimensional; thus strengthening the argument for a move towards a woman-centred, biopsychosocial approach in order to understand, prevent and manage poor CB wound healing related outcomes. It is sufficient to reason that the precipice in care following birth experienced by the women in this study may be rooted within the predominant biomedical model in obstetrics. This perspective posits safe delivery as the reason d'etre of women's antenatal journey within the healthcare system, led by clinicians as the keepers of expert knowledge (O'Mahony & Clark, 2018). Additionally, interview narratives reveal little to no recognition of the psychosocial impact of morbid post Caesarean wounds that may not be deemed serious or life threating enough to warrant medical intervention, yet have significant impact on women's maternal adjustment.

There is growing national directive towards person-centred care in both obstetrics and postoperative wound care (National Wound Care Strategy Programme, 2021; Birthrights, 2018.; Loke, Davies & Mak, 2017), however there seems to be lack of definition in regard to what this would entail in practice and how this would be standardised and measured considering the abstract meaning underlying the concept of recovery. In this regard, this study mirrors Kurz, Davis and Browne's (2021) observation that intrinsic indicators such as satisfaction, self-efficacy and empowerment are used interchangeably to illustrate the 'becoming' of women through childbirth.

Considering that prevalence of risk factors associated with surgical birth and poor operative healing are projected to increase (i.e. The Scottish Government, 2021; Childs *et al*, 2020), health psychologists are arguably in a prime position to influence delivery of sustainable interventions, by deploying skills and knowledge in the following areas.

4.4.1 Patient level education and awareness raising

The women in this study were upfront about how they felt treatment over their slow-to-heal CB wounds could be improved. Women did not anticipate the extent of their injuries, and felt they were not afforded the knowledge or confidence in mitigating and managing complex wounds independently. In this regard, they voiced a need for information that is readily accessible and prescriptive surrounding postoperative wound aetiology. These findings complement Squitieri *et al's* (2020) assessment that for the most part, standard preoperative information is inadequate in preparing the proportion of patients that go on to develop postoperative complications.

Similarly, other studies summarise that post Caesarean women had little awareness of 'red flag' indications and were not confident in identifying abnormal wound healing symptomology (Weckesser *et al*, 2019; van Griensven , Moore & Hall, 2016). This is a cause for concern, as delayed help seeking can increase wound morbidity, including necrotizing fasciitis which rarely occurs (0.18% prevalence rate) but is associated with increased risk of maternal mortality (22% death rate; in Kawakita & Landy, 2017). To this end, health psychologists have a role in working alongside patient experts in designing and piloting CB discharge packages and information assets which are economical, but simultaneously tailored to women's subjective postoperative needs.

Though postoperative complications following surgical births may be unavoidable, more can clearly be done to prevent acute symptoms such as intense pain from being ramified into a state of consistency; bearing in mind the vicious cycle between negative affect and delayed wound healing (Tomsis *et al*, 2021). In this regard, a recent systematic review found strong and consistent evidence for the positive effect of psychological intervention on generic postoperative wound healing (Robinson, Norton, Jarrett, Broadbent, 2017). On the other hand, studies that apply traditional frameworks such as the Self Regulatory Model advocate the importance of implementing practitioner skills such as motivational interviewing, as a formula for assessment, and to ensure expectations and beliefs surrounding timeframe and nature of postoperative healing are realistic and managed appropriately. This is based on the rationale that wound healing trajectories that conforms to or exceeds pre-existing recovery prototypes translates into better patient outcomes overall (Callender, Johnson & Pignatoro, 2021., Zhu *et al*, 2021).

Findings from this current study can indeed be mapped to traditional frameworks surrounding illness representations. Using Leventhal et al's (1996;1997) 5 key domains (cause, identity, timeline, control, consequence) of the Self Regulatory Model as an example; the first theme '*Tied to that event'* strongly demonstrates how the *cause* of the complex wound is linked to how women *identify* and make sense of their symptoms. Likewise, it was obvious that mismatch in women's expectations surrounding *timeline and consequence* of slow Caesarean wound healing was linked to their sense of *control* or ownership over their bodies and overall birth experience.

Despite this, it can be argued that the intricate richness of contradictions and heuristic 'double meaning' captured within women's narratives would be simplified if moulded into universal paradigms or frameworks. Therefore, care must be taken in applying these models to support new mothers, so as not to medicalise or negate the unique subjectiveness of 'birth stories' that encapsulates postnatal health beliefs. In this regard, the author is in agreement with Patel, Wittkowski, Fox & Wieck's (2013) conclusion derived from their qualitative study surrounding women's experience of post-natal depression, in that '*participants did not share these 'neat' conceptualizations…models, such as the SRM, are unable to substitute individual formulations that allow for the complexity of these beliefs*' (p.688)

Taken together, these suggests evidence for biopsychosocial and enactive approaches to post Caesarean wound care. As a specific example, the 'empowered relief' pain management programme is designed to ameliorate symptoms by enhancing women's self-regulatory ability to identify harmful thoughts and cognitively reframe pain (Darnall, 2022). This dovetails with Parratt's (2010) theory of 'empowered care' in reconfiguring postnatal vulnerability into inner-statements congruent with resilience and growth.

However, one significant criticism of short-term intervention programmes such as 'empowered relief' is the loss of social support elements that are provided by peer-based programmes. In this

respect, there is rich evidence that community interventions such as the Lindsay Leg Club, an initiative for those suffering with chronic leg related morbidity such as venous ulcers, buffers against negative affect by providing patients living with chronic wounds with a sense of belonging resulting in improved acceptance of their condition (Galazka, 2020). Similarly, Hallam *et al* (2019) explored women's experience of the Positive Birth Movement- a grassroots organisation that aims to empower new and expecting mothers via provision of free support and unbiased information. The authors propose that giving women opportunity to make sense of their experiences in a supported environment and normalise variation in birth stories provides women with tools to counteract 'good mothering' pressures. There is remit in undertaking further investigation as to how these existing resources can be harvested in order to instigate change at policy level, decrease stigma by increasing social awareness, and support women who may be more at risk from post CB maladjustment or promote resilience in those already presenting with slow-to-heal CB wounds.

4.4.2 Systems level communications & care pathways

Participants' relationships with healthcare staff within the context of the wider organisational system was a constant thread connecting women's intrapartum narratives. Emotive 'hotspots' in women's narratives were characterised by both negative and positive interactions with staff during moments of vulnerability when seeking help for wound related symptoms. Overall, women's sense of disempowerment is mirrored in various other bodies of literature surrounding wound and maternity care. This suggests a need for staff training regarding wound diagnosis/ aetiology, the psychosocial impact of CB and postoperative recovery, as well as empathic communications skills. However, there is debate surrounding the feasibility of increasing training regiments considering the high turnover of workforce in midwifery (Midwifery 2020 Programme), and lack of healthcare staff time and capacity in keeping up to date with wound care research (Flanagan, 2005). Furthermore, lack of regulation of best practice standards and entrenchment of dysfunctional systemic aptitudes towards surgical birth (i.e. staff fear of litigation; Parliamentary Office of Science and Technology, 2002; Johanson, Newburn & Macfarlane, 2002), could mean variance and inequality in application across the board. To this end, some authors have suggested integration of wound care specialists or identification of an acceptable 'change agent' responsible for campaigning cultural shifts from within organisations (Lindsay *et al*, 2017; Flanagan, 2005). This is worth exploring further, considering the success of dedicated 'champions' or in-house specialists in other areas requiring rapid modifications in clinical practice (i.e. smoking in pregnancy screening; NICE, 2021).

Additionally, the participants' accounts are consistent with other studies suggesting need for improved follow-up postnatal care in order to identify early signs of morbidity (Weiss, Fawcett & Aber, 2009). In line with salutogenetic theory, enablement to talk about traumatic perinatal experiences can afford women a sense of coherence and promote maternal resilience (Tham, Ryding & Christensson. 2010). However, there is lack of robust evidence in the literature regarding the efficacy and acceptability of existing debrief or postnatal follow-up intervention programmes (Brodribb, 2019; Sheen & Slade, 2015; Rowan, Bick & Bastos, 2007; Shaw, Levitt, Wong, Kaczorowski, 2006). It should be noted that these evaluations must be interpreted with care due to confounding factors such as lack of standardisation of staff training and service provision across maternity care (Kitzinger & Kitzinger, 2007). For example, a review of 'Listening Visits' (an intervention for postnatal women with mild to moderate depression or anxiety) concluded that

the service was most successful if delivered by health visitors who underwent additional person-centred training, indicating variance in the treatment women receive (Willis, 2018).

More recently, there has been a move towards eHealth in wound care with the aim of ensuring that rapid treatment is accessible for patients (Moore *et al*, 2015). For example, Fernandes-Taylor *et al* (2017) have released a protocol surrounding a feasibility study measuring efficacy of a smartphone app designed to monitor images sent by patients, and hence identify early postoperative wound complications. Similarly, Castillo *et al* (2016) piloted a wound surveillance app targeted at post Caesarean women for a five-month period and suggested results were promising and merited further trials. It should be noted however that this study participants' accounts of receiving postnatal support electronically due to pandemic regulations do not support this enthusiasm. The women in this study felt remote consultations were not sufficient in addressing their wound-related concerns and made them feel further frustrated and isolated. Taken together these findings suggest further research is needed to find equilibrium between fast and efficient postoperative wound care pathways, whilst not negating the 'with woman' spirit of postpartum care hallmarked by connectedness though birth story sharing (Callister, 2004) .

It is inevitable that women with complex healing Caesarean wounds will come into contact with an array of healthcare professionals with varying levels of knowledge and attitudes towards wound care. The challenge for health psychologists remains identifying, designing and evaluating an equitable intervention or training package that can be applied in a wide range of services. More recently, there has been movement in achieving this; for example, the National Wound Care Strategy Programme aims to implement a framework to address variation in wound care strategies with the wider objective of improving patient related outcomes (Fullwood, 2021). Similarly, a small-scale pilot outlined the success of a community based wound healing clinic as measured by quality of recording and referral of patients presenting with slow healing wounds at a GP surgery, improvements to clinical parameters (i.e. wound area reduction) and self-reported constructs such as quality of life (Tickle, 2021). As a more specific example, the PreCiSSIon project (West of England Academic Health Science Network, 2022) seeks to implement a care bundle designed to prevent the likelihood of SSIs post Caesarean, of which an element of this pathway includes a uniform approach in auditing CB results across the West of England region. Studies such as the current could contribute towards these projects by adding understanding of the patient experience and how specific patient groups presenting with complex wounds interface with universal pathways.

Overall, health psychologists are well-positioned to undertake further investigations in order to provide an evidence-based approach to inform healthcare staff development and provision of care, as well as guide policies and strategies associated with postoperative birth practice that can cater to the full spectrum of patient needs.

4.5 Study limitations and considerations for future directions

In order to critically appraise the study findings, there are a number of caveats that should be considered.

Firstly, this study employed a qualitative research design, meaning a small sample size was required in order to gain rich, in-depth insight into women's experiences (Thomson, Dykes & Downe, 2011). Though inability to generalise findings to the wider population may be considered a weakness, the author agrees with Dudley *et al's* (2017) reflection below regarding the value of

qualitative methodology in best capturing idiographic nuances that are relayed through human discourse, such as pain, which featured heavily across women's narratives:

"*Even the most complex of quantitative measures of pain could not emulate the poignancy expressed in the narratives of women's experiences of pain*." (p.7)

One methodological limitation worth considering was the exclusion of participants who cannot communicate in English proficiently. Additionally, the majority of participants were of White ethnicity, in a relationship at the time of birth, and had access to family support. One must therefore be cautious in applying these findings to other more disadvantaged groups (i.e. those with learning disabilities, immigrant women). In this regard, the charity Five x More (2022) suggests that the higher proportion of Black and ethnic minority requiring operative birth and suffering from worsened postnatal morbidity is the result of wider systematic racism. Similarly, studies suggest racial disparity in wound healing outcomes (i.e. Bliss *et al*, 2017) and pain management (i.e. Kennel, Withers, Parsons& Woo, 2019) are underpinned by inherent institutional discrimination. This points to the need for further investigation into the experiences of women from ethnic backgrounds that are negotiating multi-agency systems set within cultural and political contexts. Burgess-Proctor (2015) notes that feminist researchers should be mindful of perpetuating social inequalities that are already visible in healthcare structures. It is hoped that this current study can instigate further research into the perspectives and needs of women with slow-to-heal CB wounds that may face additional language, cultural and social barriers. This is of essence considering the increase of women from newly arrived communities accessing the NHS to give birth (RCOG, 2022), and who are furthermore evidenced as being more likely to require surgical births (Essex, Green, Baston & Pickett, 2013).

On the same note, evidence of midwifery staff deficiency in providing woman-centred care in the UK can also be considered the product of wider systemic failure (Sidhu, Su, Shapiro, Stoll, 2020). In this sense, it would be worthwhile conducting research into the underlying attitudes of staff towards postnatal surgical wounds, and what tools or changes would be necessitated in order to enable them to facilitate these women's needs.

Though this study honoured the IPA approach in recruiting a homogeneous sample set as much as possible (Pietkiewicz & Smith, 2012); limiting participant inclusion criteria could enhance trustworthiness of future findings. For example, this study included samples of women that had a repeat and first time Caesarean. Arguably, this could suggest different levels of expertise and expectations of postnatal healing, thus making comparisons across accounts more problematic. Another plausible suggestion for further research would be specifying wound typology or symptomology (i.e. those with post Caesarean SSI's only) in order to be able to streamline results and application to practice.

Lastly, as interviews were conducted during the tail-end of the Covid-19 pandemic; one may question how transferable study findings are given women's experiences of care will depart from the norm due to extreme measures at the time. Indeed, participants' interviews gave further understanding of how Covid-19 pandemic regulations exacerbated the sense of loss of agency and isolation women experienced. For example, social distancing restrictions meant women navigated the maternity care system without support from a significant other (i.e. partner), which seemingly instigated a sense of vulnerability from the outset. In general, current findings illustrate how overall uncertainty associated with the novel pandemic acted in synergy with the experience of navigating the 'unknowns' associated with the duality of becoming a new mother while

circumnavigating slow-to-heal wounds prognoses. Unsurprisingly, a national survey conducted with the aim of capturing women's experience of maternity care during the first Covid-19 wave indicated more women reported their basic care needs were not being met in comparison to previous years (Harrison, Alderdice, McLeish, Quigley, 2020). Though women's experience during the Covid-19 pandemic are not typical of standard care, it can be argued that this study's findings allows insight into the experiences of those who are less visible in academic participation and who are more likely to exist on the fringes of society. For example, newly arrived women who may be displaced from family (i.e. due to conflict in their countries of origin) and who may lack confidence in navigating the UK healthcare system. Moreover, Covid-19 protection measures involving distancing and social isolation during the perinatal period were identified as risk factors for postpartum depression (Chen, Li , Xiong & Zheng, 2022). Therefore, it would be worthwhile to conduct follow-up investigations in order to explore the cumulative biopsychosocial impact of seeking care for complex postnatal wounds during the Covid-19 pandemic, for example on reproductive decision making.

4.6 Conclusion

The objective of this study was to examine new mother's experiences of living with slow-to-heal CB wounds using an interpretative phenomenological approach. More specifically, this study aimed to answer the following main research question:

- What are the emotional and psychosocial implications of living with slow-healing CB wounds?

The secondary question the study aimed to address was:

- How can these findings inform further research into current policy and practice considerations?

Findings derived from interviews with seven participants enhance understanding of recovery from slow-to-heal CB wounds as multifactorial, wherein the physical wounds present as the 'tip of an iceberg' (see diagram in page 35). This metaphor was originally employed by Edge & Rogers (2005) to describe Black Caribbean women's meaning making of postpartum depression, and has been adapted to suit the current study aims in illustrating the complex interactivity between slow-to-heal post-surgical wounds as a manifestation of CBs as a didactic event. This study corresponds to other findings suggesting it is not simply the clinical indication of wounds that predicts maladjustment, but rather the subjective meaning assigned to the wounds in terms of integration into an acceptable self-identity or 'new normality'. There are clear parallels between current study findings and what is already known in the literature, with repetition of near identical themes. However, this is the first study to focus specifically on postpartum women's psychosocial experience of living with slow-to-heal CB wounds. To this end, this study contributes to new understanding of slow-to-heal postsurgical Caesarean wounds as emblematic of subjective paradigms surrounding perceived control and maternal identity attainment within the unique psychosocial context of CB. Findings complement wider knowledge regarding the role of health professionals and significant others as conduits of agency (Brown, Tanner & Padleym 2014; Hopkins, 2004). For the most part, women's accounts of seeking professional care for slow-healing CB wounds were underlined by narratives of power disequilibrium rooted in medical decision-making leading to surgical birth; thus highlighting the need for 'with-woman' approaches in postpartum wound-care. Variance across narratives were likewise framed within discourse

surrounding subjective postpartum expectations of how important it was in fulfilling 'good mothering' roles within an expected timeframe, which were unattainable due to extended physical disability.

Study findings reveal how prolonged Caesarean wound healing contributes towards a sense of loss of coherence as new mothers learned to live with the volatility of a misfunctioning body. Persistency of somatic symptoms, in particular scar related pain, seemingly served to remind women of their loss - be it a previous prepartum self or a body as a symbol of reproductive femininity. In this regards, women synonymised healing as ability to reach a sense of normality. While there were disparities across women's definitions of normality, most of the women's narratives of living with slow-to-heal wounds can be summarised as the 'unimaginable', hence normality would involve lessened disparity between idiographic notions of the 'imaginable' and 'unimaginable'. In essence, this would entail regaining a feeling of 'wholeness' and being able to undertake roles and tasks categorised as 'taken for granted' in order to be able to self-define as a 'good mother'.

The iceberg metaphor is particularly relevant in terms of women's experiences of support seeking for slow-to-heal wounds (see diagram in page 35), and informs suggestions for further research based on findings. Women's narratives indicate that for the most part, healthcare staff responses to CB wounds are seemingly guided by biomedical 'tip of the iceberg' approaches in assessing clinical wound parameters. Wider literature corroborates this, and findings highlighting staff dismissive attitudes suggests limited evidence of due consideration into the underlying reciprocity between slow healing wounds and women's overall adjustment following a CB. This revelation mirrors wider concerns for the overall lack of holistic recognition of the person living with the wound in current healthcare policies and practice (Sen & Roy, 2019).

In summary, existing literature on women's CB experiences are largely based on the assumption of recovery as a universal entity. Whilst as this study has generated new considerations concerning the complexities of poor post Caesarean wound healing not previously explored in depth. Findings indicate that women's resilience and ability to adjust to their slow-to-heal postnatal wounds are largely determined by the subjective meaning placed on the overall CB experience as a juxtaposition between childbirth and surgery. This is important to note, as findings indicate a need to expand discourse surrounding post Caesarean healing from assumptions based on positivist classification systems and one-size-fits-all formulations. This supports the overarching biopsychosocial framework suggesting a reciprocal relationship between healing metrics as determined by the person living with the wound (i.e. pain) and wider determinants that are not likely captured by standard PROMS (i.e. maternal sense of coherence). In this regard, further research in the area is suggested in order to capitalise on directives toward person-centred ethos in both wound and maternity care guidelines.

Post Caesarean wound care is an important area of development as a positive postpartum contributes towards a sense of inner growth as women go through an important identity transition in their lives. Conversely, an unsatisfactory postpartum can be internalised by women as a negative, and even traumatic birth narrative. Considering the link between poor postpartum adjustment and worsened mother-infant outcomes, in addition to the increase of risk factors underlying CB wound morbidity, ignoring the issue may contribute towards widening and entrenchment of inequalities which may be passed on to generations to come.

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Appendices

Appendix 1- Patient and Public Involvement feedback matrix

1A. PPI feedback- interview guide

Section/theme	PPI feedback	Researcher comments/ actions
Q2. Can you tell me a bit about your childbirth and how you came to have an unplanned Caesarean? Prompts: What happened? What were your feelings at the time?	**PPI 1:** I read it as my own, in term of when I was born. Maybe 'birth experience'? the 'birth of your child/children'?	Changed 'childbirth' to 'Caesarean birth experience'
Q3. Can you tell me more about your Caesarean wound and how this has affected your daily life? Possible prompts: In what ways? How does this make you feel?	**PPI 1:** Are you going to stick to first time mums or include people with more than one csection (repeats, over scar tissue can be tougher to recover from)**.** Verbal comment that it may be useful to recruit 2nd+ time Mums as they may be able to compare experiences in the interview.	Not only 1st time Mums will be recruited, included a prompt 'Comparison to previous births (if applicable) to Q2 above' This comparison prompt can be carried on throughout the interview for Mums that are not 1st time Mums.
Q4. How have you managed your wound while also balancing the role of being a new Mother? Possible prompts: In what ways? How does this make you feel?	**PPI 1**: Have any support from partners, family or friends? Also, impact on bonding with baby? Impact on breastfeeding maybe (trust me, it was a challenge to find a comfortably position during the first few weeks and handle a baby on the breast!). Verbal comment that baby feeding in general (inc bottle-feeding) would be relevant as preparing bottles and the routine surrounding bottle-feeding also requires physical movement and positioning.	Interviewer footnote to include prompts surrounding practical aspects of motherhood such as feeding, and emotional aspects such as social support.
Q5. Can you tell me a bit about your family, and what effect the slow healing wound has had on your family dynamics? Prompts: relationship with partner if	**PPI 1:** Include getting out the house to see family? The physical impact of having a CS and getting out the house with a new-born can be physically and mentally a challenge. Verbal comment	Added the prompt 'relationship with extended family if applicable' as in some cultures extended families are more involved in child rearing.

applicable, relationship with other children.	on dealing with 'expectation', family visiting can also be an issue.	
Q6. How do you feel about your antenatal preparation in regards to your caesarean wound? Possible prompts: In what ways? How do you feel in light of what you know now?	**PPI 1:** Oh great question, the system is so geared up for natural Vaginal birth that a CS can come as a surprise or even be seen as an easy way out (famous Victoria Beckham and the 'too posh to push' springs to mind). Verbal comment that due to the time period I am recruiting, participants may only have been able to access long distance antenatal classes (validity of results?). Discussed how different type of antenatal preparation (i.e. paid vs unpaid), may impact on experiences.	Added prompt 'how could this be different' as it is a good point that antenatal services would be much changed due to Covid-19 during the period under investigation.
Q7. How do you feel about the treatment you are currently receiving for your Caesarean wound? Possible prompts: In what ways? How do you think this changes your situation?	**PPI 1:** I didn't get any other than the 5day check on new-born and CS scar and then at the 6w, perhaps that is different answers depending on NHS trust? Verbal comment to perhaps compare postnatal care systems globally.	As per above, added the prompt 'how could this be different'
Q8. Do you think your Caesarean wound has impacted on your views on motherhood/ pregnancy? If so, how? Possible prompts: Why do you think this has changed?	**PPI 1:** Has it impacted on bonding with the baby? Breastfeeding? Desire to have more children? Although those can be very leading questions… Verbal comment on impact on birth choices, perhaps 'pregnancy' should be changed to 'childbirth'.	Changed 'pregnancy' to 'childbirth'
Q9. How do you foresee your wound healing? What impact do you think this will have? Possible prompts: In what ways? How does this make you feel?	**PPI 1:** Physically and mentally	

Q10. Can you describe what you think your life would be like if you did not have this non-healing Caesarean wound? Possible prompts: How does this make you feel?	**PPI 1:** I think, unless they've had the experience of a vaginal birth it's hard to know isn't it how it really affects the first few weeks of new-born and recovery.	Non 1st time Mothers can use comparisons. However, the wording 'you think' in the question is designed to explore expectations surrounding motherhood.
Q11. Do you want to discuss any other aspects we have missed? If so, please elaborate	**PPI 1**: Perhaps more on the level of support they had during the recovery and if they had any support past the 6 weeks?	This should be covered in Q7
Overall Comment	**PPI 1**: I think that the questions are fair and should give you a good understanding of their recovery (both physical and mental). **PPI2**: Verbal comment that the interview questions are comprehensive, no feedback for improvements. **PPI4**: Delayed wound healing impact as a nuisance instead of having an impact on quality of life, used example of embarrassment over oozing wounds.	This should be covered in Q3

Appendix 1B. PPI feedback- participant information sheet

Section/ Topic	PPI feedback	Researcher comment/ Actions
General feedback	**PPI 1:** Felt it was clear and no feedback as such given apart from a minor grammatical	N/A

	amendment. PPI 1 recognised that this may also be because she has an academic background and suggested recruiting someone with lived experience and a non-academic background to form part of the PPI. Agreed that giving the option of undertaking the interview in more than 1 sitting would work better for those with young babies. **PP2**: Verbal feedback that the information sheet was clear enough, verbal consent should be appropriate 'women would want to share their experiences with the hope of helping others that are in the same position'.	

Appendix 1C. PPI feedback- study design

PPI summary:

PPI1 is a Mother that had responded affirmatively to the PPI call for women that has experienced delayed CS wound healing, she had an unplanned CS approximately 3 years ago in an NHS facility.

PPI2 is also a Mother that had responded to the PPI call as per above, she had an unplanned CS approximately 7 years ago in an NHS facility.

PPI3 is a General Practitioner in London that has been in practice for more than 5 years.

PPi4 is a Midwife in a London maternity unit that leads the birth reflection clinics.

Section/ theme	PPI feedback	Researcher comments/ actions
Participant recruitment	**PPI 1:** Perhaps contact Tommy's (the charity) as they give support for pregnancy, loss and recovery after c-sections, they have a large online platform and may be able to put you in contact with others. Most NHS trusts will have their own support service post baby (I have the details for my local one in Bedfordshire if you want) who can also help? Also, see if you can speak with Pregnant Then Screwed (insta platform) whom are very vocal about support around pregnancy, delivery and covid currently and might take an interest in your research? **PPI2**: Discussed how Covid-19 would impact on participant recruitment, but felt that I should be able to recruit participants online. **PPI4**: It would be difficult recruiting via the NHS as after 6 weeks women are discharged to the community. Best option is to recruit via social media platforms.	Grassroots organisations added to the list of places participants will be recruited from.

Clinical definition surrounding non-healing CS wound (6 weeks post operation)	**PPI 1**:6 weeks is what I was always told and expected, it tied in with the 6w baby checks that you get through the GP when they tend to ask a couple of questions about your wellbeing and I was asked about my healing. It certainly seems like 'industry standard' however, I do think that in many cases, healing certainly takes longer (with caring for a baby, maybe older kids too) and there is a total disconnect between recovery from emergency CS and paternity leave, which is only 2 weeks and then you are left to fend for yourself whilst still barely able to get up and down! **PP2**: Agreed that 6 weeks is sufficient for wound healing, and anything that surpassed this would be 'problematic'. PP2 reflected that though she had a lot of issues with her wound healing, this did heal within 6 weeks though she never returned to as before-numbness in stomach area below where the incision is. We discussed how some women may define this as delayed healing, therefore maybe we need to be more clinical with the inclusion criteria (i.e. exclude numbness and chronic pain? Be more specific regarding physical wound definition only?). **PPI3**: Be aware of the differences in definition between 'delayed' and 'chronic', the latter relates more to non-healing or longer term healing in which case the 6 weeks minimum would be suitable. However, in the case of 'delayed' healing it is anticipated that a CS wound should be sufficiently healed (i.e. sutures all joined up) by 2 weeks. Feedback that it will be very difficult to recruit participants with non-healing after 6 weeks (PPI has never encountered this in her clinical experience, she says 2 weeks would be sufficient). We discussed how the delayed healing can be a manifestation of psychological symptoms instead of actual physical symptoms (she	Include non-restrictive description of delayed healing examples, i.e. dehiscence, wound not joining, abscess, etc, in study call to offer clarity to potential participants while still respecting subjective experiences Change inclusion criteria from 6 weeks to 4 weeks?

	used an example of a woman with PND). Perhaps we need to include a description of what we mean by delayed healing in our study call? I.e. wound dehiscence/ edges not joining, infection 'redness, soreness, oozing, odour'. It was discussed that 'pain' or 'prolonged bleeding' as indicators of internal non-healing might not be suitable indicators, as this can vary naturally in postnatal women. Also made a comment where it is mentioned 'that the 'uncomplicated' CS wound should be healed within 14 days. Furthermore, this end of healing stage should be marked by the removal of wound clips or staples (Bullough, 2014)'. Staples are used in circumstances where stitches/ glue are not ideal, i.e. in obese women.	Change terminology from 'chronic; and 'non-healing to 'delayed' and/or 'slow' healing'
	PPI4: Feedback mirrored the input of PPI3, in that wounds should be healed within 10-14 days. Again, there is a concern that we will have difficulty recruiting to the inclusion criteria of women that have not healed after 6 weeks as this is 'extremely rare'. She mentioned that as she would expect wounds to be healed within 2 weeks, it would be appropriate to define delayed healing as CS wounds that have not healed by 3-4 weeks. However, there was some recognition of the subjective aspects of healing. For example, she mentioned she would expect to see little 'gapes' in the CS wound that may 'ooze' as part of the healing process, while as this may be perceived as 'non-healing' by the patient. She agreed that we may have more success in recruiting patients that are experiencing prolonger pain after 6 weeks. We discussed how pain perception is part of the subjective experience of healing, and how differing in sensations such as numbness could be perceived as 'non-healing'.	See above

	Input that the 6 week timeline for healing advocated by patient information sources are outdated, and based on practices from around 20 years ago (i.e. using staples) that resulted in slower healing wounds compared to current standards.	
PPI recruitment/ retainment	**PPI3:** Mentioned that GPs would be suitable as these would usually be the first point of call in regards to delayed CS healing. However, a specialist GP/ obstetrician would be more suitable. **PPI4**: A specialist obstetrician would be suitable, preferably one with many years' experience and is able to compare how changes in procedures has impacted on recovery.	
General comment	**PPI4:** Women have more issues with delayed perineal healing compared to delayed CS healing. Further discussion that the 'emergency' aspect of a birth intervention has a significant psychological impact on healing.	

Appendix 2- PPI engagement reflection

I initially identified and invited two suitable candidates to act as the study PPI in late February/ early March 2021, which consisted of one woman with lived experience and one research midwife. Both contacts were recruited via snowballing; the research midwife was identified through my work role training obstetric staff at a North West London hospital trust. The woman with lived experience was identified via word of mouth and consented to being contacted about the study . In my introduction email/ text to them, I explained what their roles as a PPI representative would entail and offered a voucher or charity contribution to the value of £20 as a reimbursement of their time upon completion of their role. Both individuals expressed an interest and were followed up via telephone, wherein both individuals verbally agreed to act as the study PPI.

Despite the midwife initially agreeing to form part of the PPI, we did not manage to maintain this arrangement. After becoming non-responsive, I decided to cast my net wider to include other relevant clinical groups, such as general practitioners and health visitors.

In their article, Jackson *et al* (2020, p5) reflected that '*a properly funded supportive organisational infrastructure is integral to implementing meaningful PPI and reducing unintentional tokenism*'. As a novice researcher with limited experience, I agree with this observation. On reflection, I believe barriers to clinical PPI involvement could be due to lack of understanding of academic research and lack of confidence in University ethics procedures. In this regard, I was forthcoming with the clinicians that the study would not go through NHS ethics approval for pragmatic reasons. Though I assured the clinical representatives that the study would be subject to rigorous academic ethics assessments, there was still a sense this was perceived as high-risk or not directly benefiting patients in their care.

Ultimately, this study was informed and shaped by informal public voices throughout. For example, I changed Caesarean Section terminology into Caesarean Birth following advice from a social media gatekeeper that women who have given birth via Caesarean may find the former wording marginalising and triggering. As another example, I extended the eligibility criterion from one year post birth to two years following a woman with lived experience's feedback that mothers living with slow-to-heal Caesarean wounds may not be able or willing to participate in research during the first year. This suggestion complements Williams *et al* (2018) statement that early postnatal challenges should be considered as a barrier in research recruitment.

Appendix 3- Study call

Have you had a Caesarean birth?
And is (or had) your wound taken longer to heal?

If so, we would like to hear your experiences and perspectives.

This research aims to understand the issues that women face navigating motherhood while living with a slow-to-heal caesarean wound. It may help improve care strategies aimed at women and their families in the future.

We are seeking to interview women who:

- are over the age of 18
- have given birth via Caesarean in the UK in the past 24 months
- have (or had) Caesarean wounds that are taking (or took) longer to heal, e.g.: wounds that re-opened or had not closed after 2 weeks, discharge, prolonged wound site pain, etc.
- and can take part in an interview conducted by video call or telephone, in English.

If interested in taking part or want more information, please contact: Clementine Djatmika (Health Psychology doctorate student) on clementine2.djatmika@live.uwe.ac.uk, or scan this QR code:

* This research has received ethics approval from the University of the West of England Bristol*

Appendix 4- Participant information sheet

Study title: The experiences of women living with a slow-healing Caesarean wound

You are invited to take part in a research study. Before you decide whether to take part, it is important for you to understand why the study is being done and what it will involve. Please read the following information carefully and if you have any queries or would like more information please contact Clementine Djatmika, Faculty of Health and Applied Science, University of the West of England, Bristol at clementine2.djatmika@live.uwe.ac.uk

This study will be supervised by Professor Diana Harcourt (Director of Studies): diana2.harcourt@uwe.ac.uk, Dr Heidi Williamson (2nd Supervisor): heidi3.williamson@uwe.ac.uk and Dr Joanne Lusher (3rd Supervisor): joanne.lusher@uws.ac.uk

What is the aim of the research?

The research is looking at the experiences of women living with Caesarean wounds that are taking longer than anticipated to heal. Our research questions are: What are the social and emotional experiences of new Mothers that are living with slow-to-heal Caesarean wounds? In addition, what are the challenges these women face? To help us answer these questions we will be conducting interviews.

The research is being conducted as part of the first researchers Professional Doctorate in Health Psychology final thesis, and the results will be included in her final thesis, which will be available on the University of the West of England's open-access repository. The anonymised results may also be used in conference papers and peer-reviewed academic papers.

Why have I been invited to take part?

You have been invited to take part as you are over 18, have undergone a Caesarean procedure in a UK health facility, and have experienced or is still experiencing Caesarean wound complications or delayed healing (i.e. wound not closing more than 2 weeks postpartum). You have responded to the study call for participants, and have asked for more information.

Do I have to take part?

You do not have to take part in this research. It is up to you to decide whether or not you want to be involved. If you do decide to take part, you will be given a copy of this information sheet to keep and will be asked to give verbal consent. If you do decide to take part, you are able to withdraw from the research without giving a reason up until 2 weeks after your interview. If you want to withdraw from the study within this period, please e-mail Clementine Djatmika.

What will happen to me if I take part and what do I have to do?

If you are happy to take part then we will e-mail you the consent procedure, privacy notice and a copy of the interview guide. The interview should take no longer than 60 minutes, or can be broken down into shorter sessions if this is more suitable for you. The interview will be done at a time suitable to you, and can be undertaken over the phone or over a virtual video conferencing software. The interviewer will be following UWE guidance surrounding conducting research safely during Covid-19.

'Plan Z and then off the edge of a cliff': an interpretative phenomenological analysis of mothers' experience of living with a slow-to-heal Caesarean wound.

Your interview will be recorded on a voice recorded or over the virtual software. A unique pseudonym will be used to re-identify you if you choose to withdraw from the study within the period.

What are the benefits of taking part?

There are no direct benefits of taking part. It is anticipated that this study will shed more light and inform further research into the experiences of new Mothers living with slow-to-heal Caesarean wounds.

What are the possible risks of taking part?

We do not foresee or anticipate any significant risk to you in taking part in this study. If your experiences around your pregnancy/ birth/ motherhood/ Caesarean wound being slow-to-heal are topics that feel upsetting for you, then please consider carefully whether you want to take part. If you do decide to take part but feel uncomfortable at any time during the interview, you can ask for the interview to stop and will be given the option of withdrawing your interview data from further analysis. Contact details for support agencies are listed below, and will also be provided after your interview, should you feel you need support about this topic at any stage.

What will happen to your information?

The interview will be recorded for research purposes, however recordings will be destroyed securely immediately after anonymised transcription. Your anonymised data will be analysed together with other interview and file data, and we will ensure that there is no possibility of identification or reidentification from this point.

Where will the results of the research study be published?

A hard copy of the findings will be made available to all research participants if requested. Key findings will also be shared both within and outside the University of the West of England. Anonymous and non-identifying direct quotes may be used for publication and presentation purposes. We are hoping to publish our findings in relevant journals and seminars aimed at maternity staff, policy makers and other academics in the field.

Who has ethically approved this research?

The project has been reviewed and approved by the University of the West of England Research Ethics Committee. Any comments, questions or complaints about the ethical conduct of this study can be addressed to the Research Ethics Committee at the University of the West of England at: Researchethics@uwe.ac.uk

What if I have more questions or do not understand something?

If you would like any further information about the research, please contact in the first instance: Clementine Djatmika at clementine2.djatmika@live.uwe.ac.uk

Where can I get further support?

If considering participating in this study has raised concerns about your physical health or well-being, please contact your GP in the first instance, or any of the following organisations:

Family lives, www.familylives.org.uk, 0808 800 2222

‘Plan Z and then off the edge of a cliff’: an interpretative phenomenological analysis of mothers’ experience of living with a slow-to-heal Caesarean wound.

The National Childbirth Trust, www.nct.org.uk, 0300 330 0700

Birth Trauma Association, www.birthtraumaassociation.co.uk, enquiries@birthtraumaassociation.org.uk

Thank you for considering taking part in this study.

You will be given a copy of this Participant Information Sheet to keep.

Appendix 5- Verbal consent form

Study Title: The experiences of women living with a slow-healing Caesarean Section wound

This consent form will have been given to you with the Participant Information Sheet. Please ensure that you have read and understood the information contained in the Participant Information Sheet and asked any questions before you agree to participate. If you have any questions please contact Clementine Djatmika, whose details are set out on the Participant Information Sheet Once you are happy to take part in the interview, a verbal consent will be recorded:

- I have read and understood the information in the Participant Information Sheet;
- I have been given the opportunity to ask questions about the study;
- I have had my questions answered satisfactorily by the research team;
- I agree that anonymised quotes may be used in the final report of this study;
- I understand that my participation is voluntary and that I am free to withdraw at any time until two weeks after the interview, without giving a reason.
- I agree to take part in the research

‘Plan Z and then off the edge of a cliff’: an interpretative phenomenological analysis of mothers’ experience of living with a slow-to-heal Caesarean wound.

Appendix 6- Privacy notice

Purpose of the Privacy Notice

This privacy notice explains how the University of the West of England, Bristol (UWE) collects, manages and uses your personal data before, during and after you participate in this research study. ‘Personal data’ means any information relating to an identified or identifiable natural person (the data subject). An ‘identifiable natural person’ is one who can be identified, directly or indirectly, including by reference to an identifier such as a name, an identification number, location data, an online identifier, or to one or more factors specific to the physical, physiological, genetic, mental, economic, cultural or social identity of that natural person.

This privacy notice adheres to the General Data Protection Regulation (GDPR) principle of transparency. This means it gives information about:

- How and why your data will be used for the research;
- What your rights are under GDPR; and
- How to contact UWE Bristol and the project lead in relation to questions, concerns or exercising your rights regarding the use of your personal data.

This Privacy Notice should be read in conjunction with the Participant Information Sheet and Consent Form provided to you before you agree to take part in the research.

Why are we processing your personal data?

UWE Bristol undertakes research under its public function to provide research for the benefit of society. As a data controller we are committed to protecting the privacy and security of your personal data in accordance with the (EU) 2016/679 the General Data Protection Regulation (GDPR), the Data Protection Act 2018 (or any successor legislation) and any other legislation directly relating to privacy laws that apply (together “the Data Protection Legislation”). General information on Data Protection law is available from the Information Commissioner’s Office (https://ico.org.uk/).

How do we use your personal data?

We use your personal data for research with appropriate safeguards in place on the lawful bases of fulfilling tasks in the public interest, and for archiving purposes in the public interest, for scientific or historical research purposes.

We will always tell you about the information we wish to collect from you and how we will use it.

We will not use your personal data for automated decision making about you or for profiling purposes.

Our research is governed by robust policies and procedures and, where human participants are involved, is subject to ethical approval from either UWE Bristol’s Faculty or University Research Ethics Committees. This research has been approved by the UWE Research Ethics Committee. The research team adhere to the **Ethical guidelines of the British Educational Research Association (and/or the principles of the Declaration of Helsinki, 2013) and the principles of the General Data Protection Regulation (GDPR).**

'Plan Z and then off the edge of a cliff': an interpretative phenomenological analysis of mothers' experience of living with a slow-to-heal Caesarean wound.

For more information about UWE Bristol's research ethics approval process, please see our Research Ethics webpages at:

www1.uwe.ac.uk/research/researchethics

What data do we collect?

The data we collect will vary from project to project. Researchers will only collect data that is essential for their project. The specific categories of personal data processed are described in the Participant Information Sheet provided to you with this Privacy Notice; this includes your answers to the interview questions that will be anonymised.

Who do we share your data with?

We will only share your personal data in accordance with the attached Participant Information Sheet and your Consent.

How do we keep your data secure?

We take a robust approach to protecting your information with secure electronic and physical storage areas for research data with controlled access. If you are participating in a particularly sensitive project, UWE Bristol puts into place additional layers of security. UWE Bristol has Cyber Essentials information security certification.

Alongside these technical measures, there are comprehensive and effective policies and processes in place to ensure that users and administrators of information are aware of their obligations and responsibilities for the data they have access to. By default, people are only granted access to the information they require to perform their duties. Mandatory data protection and information security training is provided to staff and expert advice available if needed.

How long do we keep your data for?

Your personal data will only be retained for as long as is necessary to fulfil the cited purpose of the research. The length of time we keep your personal data will depend on several factors including the significance of the data, funder requirements, and the nature of the study. Specific details are provided in the attached Participant Information Sheet, recordings will be destroyed securely after transcription. Anonymised data that falls outside the scope of data protection legislation as it contains no identifying or identifiable information may be stored in UWE Bristol's research data archive or another carefully selected appropriate data archive.

Your Rights and how to exercise them

Under the Data Protection legislation you have the following **qualified** rights:

(1) The right to access your personal data held by or on behalf of the University;

(2) The right to rectification if the information is inaccurate or incomplete;

(3) The right to restrict processing and/or erasure of your personal data;

(4) The right to data portability;

(5) The right to object to processing;

(6) The right to object to automated decision making and profiling;

(7) The right to complain to the Information Commissioner's Office (ICO).

Please note, however, that some of these rights do not apply when the data is being used for research purposes if appropriate safeguards have been put in place.

We will always respond to concerns or queries you may have. If you wish to exercise your rights or have any other general data protection queries, please contact UWE Bristol's Data Protection Officer (dataprotection@uwe.ac.uk).

If you have any complaints or queries relating to the research in which you are taking part please contact either the research project lead, whose details are in the attached Participant Information Sheet, UWE Bristol's Research Ethics Committees (research.ethics@uwe.ac.uk) or UWE Bristol's research governance manager (Ros.Rouse@uwe.ac.uk)

v.1: This Privacy Notice was issued in April 2019 and will be subject to regular review/update.

Appendix 7- Debrief/ thank you email

Thank you for taking part in this study *the experiences of women living with a slow-healing caesarean Section wound*. It is anticipated that this study will help gain further understanding of women’s experiences mothering a newborn while recovering from surgical wounds that have taken longer to heal than what is constituted as the standard healing period.

If you would like further information about this study, would like to see a copy of your interview transcript or would like to know what the findings are, please contact me at clementine2.djatmika@live.uwe.ac.uk.

If you have changed your mind, and no longer want your answers analysed as part of an anonymised dataset, please contact me using the email address above no longer than 2 weeks after participating in your research.

If participating in this research has raised any concerns about your physical health or well-being, please contact your GP in the first instance, or any of the following organisations:

Family lives, www.familylives.org.uk, 0808 800 2222

The National Childbirth Trust, www.nct.org.uk, 0300 330 0700

Birth Trauma Association, www.birthtraumaassociation.co.uk, enquiries@birthtraumaassociation.org.uk

Appendix 8- Participant Interview topic guide

1. Can you tell me a bit about yourself? I.e. age, occupation, relationship status, ethnicity, parity, when you had the Caesarean, type of Caesarean (i.e. repeat) in order to frame interview.

2. Can you tell me a bit about your Caesarean birth experience and how you came to have a Caesarean? Prompts: What happened? What were your feelings at the time? Comparison to previous birth(s) if applicable?

3. Can you tell me more about your Caesarean wound and how this affected or is affecting your daily life? Possible prompts: In what ways? How did this make you feel? **Only for mothers with a current slow-healing wound**: How do you foresee your wound healing? What impact do you think this will have? Possible prompts: In what ways? How does this make you feel? what you think your life would be like if you did not have this nonhealing Caesarean wound?

4. How did you or how are you managing your wound while also balancing the role of being a new Mother? Possible prompts: In what ways? How did/does this make you feel? Can you describe the emotional impact? Can you describe the practical impact?

5. Can you tell me a bit about your family, and what effect the slow healing wound had or is having on your family dynamics? Prompts: relationship with partner if applicable, relationship with other children if applicable, relationship with extended family if applicable.

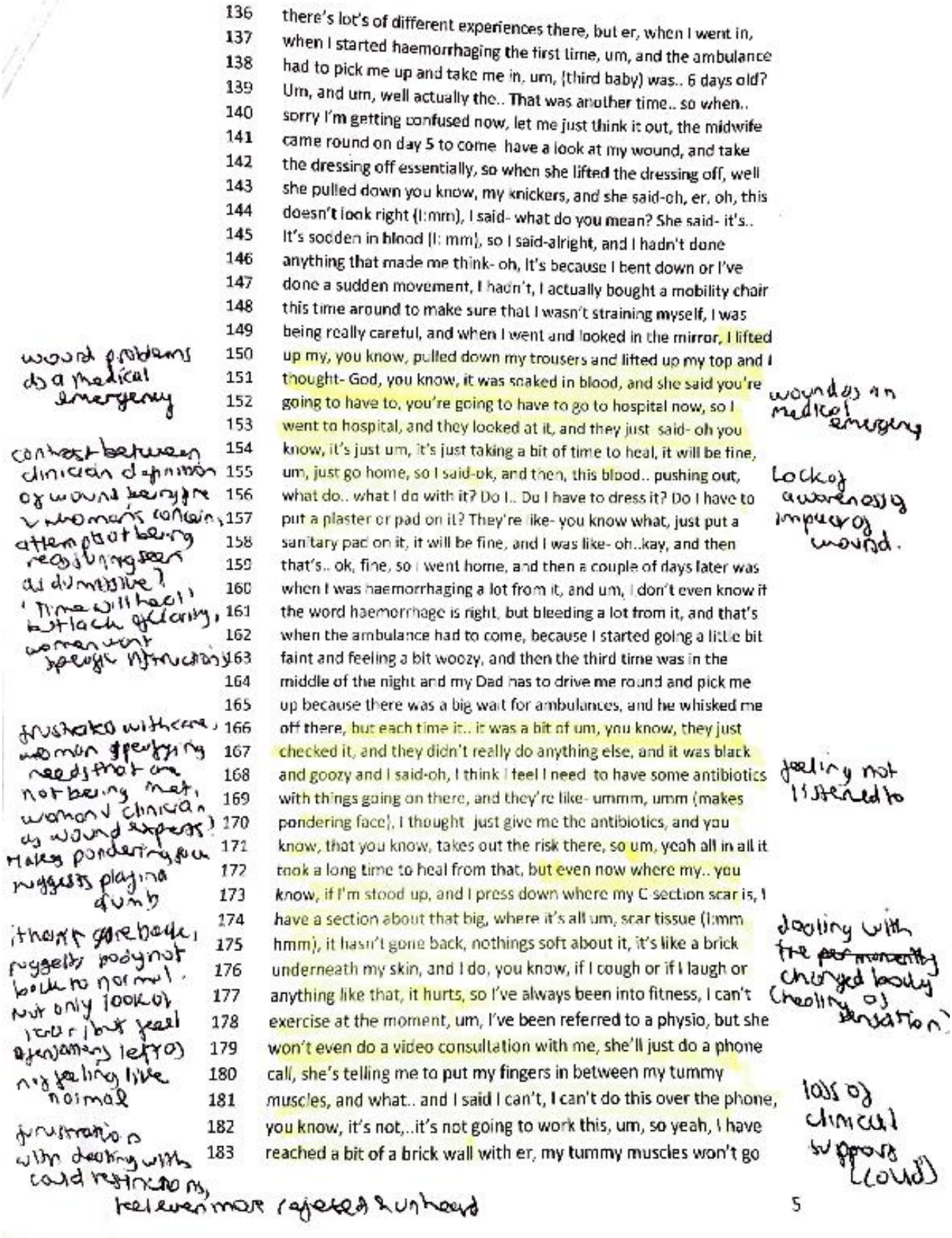
6. How do you feel about your antenatal preparation in regards to your caesarean wound? Possible prompts: In what ways? How do you feel in light of what you know now? How could this be different?

7. How do you feel about the treatment you are currently receiving or have received for your Caesarean wound? Possible prompts: In what ways? How do you think this changes/ changed your situation? How could this be different? What does full recovery mean for you?

8. Do you think your experiences in regards to your Caesarean wound has impacted on your views on motherhood/ childbirth? If so, how? Possible prompts: Why do you think this has changed?

9. Do you want to discuss any other aspects we have missed? If so, please elaborate.

Appendix 9- Sample participant interview transcript with first and second stage analysis



there's lot's of different experiences there, but er, when I went in, when I started haemorrhaging the first time, um, and the ambulance had to pick me up and take me in, um, (third baby) was.. 6 days old? Um, and um, well actually the.. That was another time.. so when.. sorry I'm getting confused now, let me just think it out, the midwife came round on day 5 to come have a look at my wound, and take the dressing off essentially, so when she lifted the dressing off, well she pulled down you know, my knickers, and she said-oh, er, oh, this doesn't look right (I:mm), I said- what do you mean? She said- it's.. It's sodden in blood (I: mm), so I said-alright, and I hadn't done anything that made me think- oh, it's because I bent down or I've done a sudden movement, I hadn't, I actually bought a mobility chair this time around to make sure that I wasn't straining myself, I was being really careful, and when I went and looked in the mirror, I lifted up my, you know, pulled down my trousers and lifted up my top and I thought- God, you know, it was soaked in blood, and she said you're going to have to, you're going to have to go to hospital now, so I went to hospital, and they looked at it, and they just said- oh you know, it's just um, it's just taking a bit of time to heal, it will be fine, um, just go home, so I said-ok, and then, this blood.. pushing out, what do.. what I do with it? Do I.. Do I have to dress it? Do I have to put a plaster or pad on it? They're like- you know what, just put a sanitary pad on it, it will be fine, and I was like- oh..kay, and then that's.. ok, fine, so I went home, and then a couple of days later was when I was haemorrhaging a lot from it, and um, I don't even know if the word haemorrhage is right, but bleeding a lot from it, and that's when the ambulance had to come, because I started going a little bit faint and feeling a bit woozy, and then the third time was in the middle of the night and my Dad has to drive me round and pick me up because there was a big wait for ambulances, and he whisked me off there, but each time it.. it was a bit of um, you know, they just checked it, and they didn't really do anything else, and it was black and goozy and I said-oh, I think I feel I need to have some antibiotics with things going on there, and they're like- ummm, umm (makes pondering face), I thought just give me the antibiotics, and you know, that you know, takes out the risk there, so um, yeah all in all it took a long time to heal from that, but even now where my.. you know, if I'm stood up, and I press down where my C-section scar is, I have a section about that big, where it's all um, scar tissue (I:mm hmm), it hasn't gone back, nothings soft about it, it's like a brick underneath my skin, and I do, you know, if I cough or if I laugh or anything like that, it hurts, so I've always been into fitness, I can't exercise at the moment, um, I've been referred to a physio, but she won't even do a video consultation with me, she'll just do a phone call, she's telling me to put my fingers in between my tummy muscles, and what.. and I said I can't, I can't do this over the phone, you know, it's not,..it's not going to work this, um, so yeah, I have reached a bit of a brick wall with er, my tummy muscles won't go

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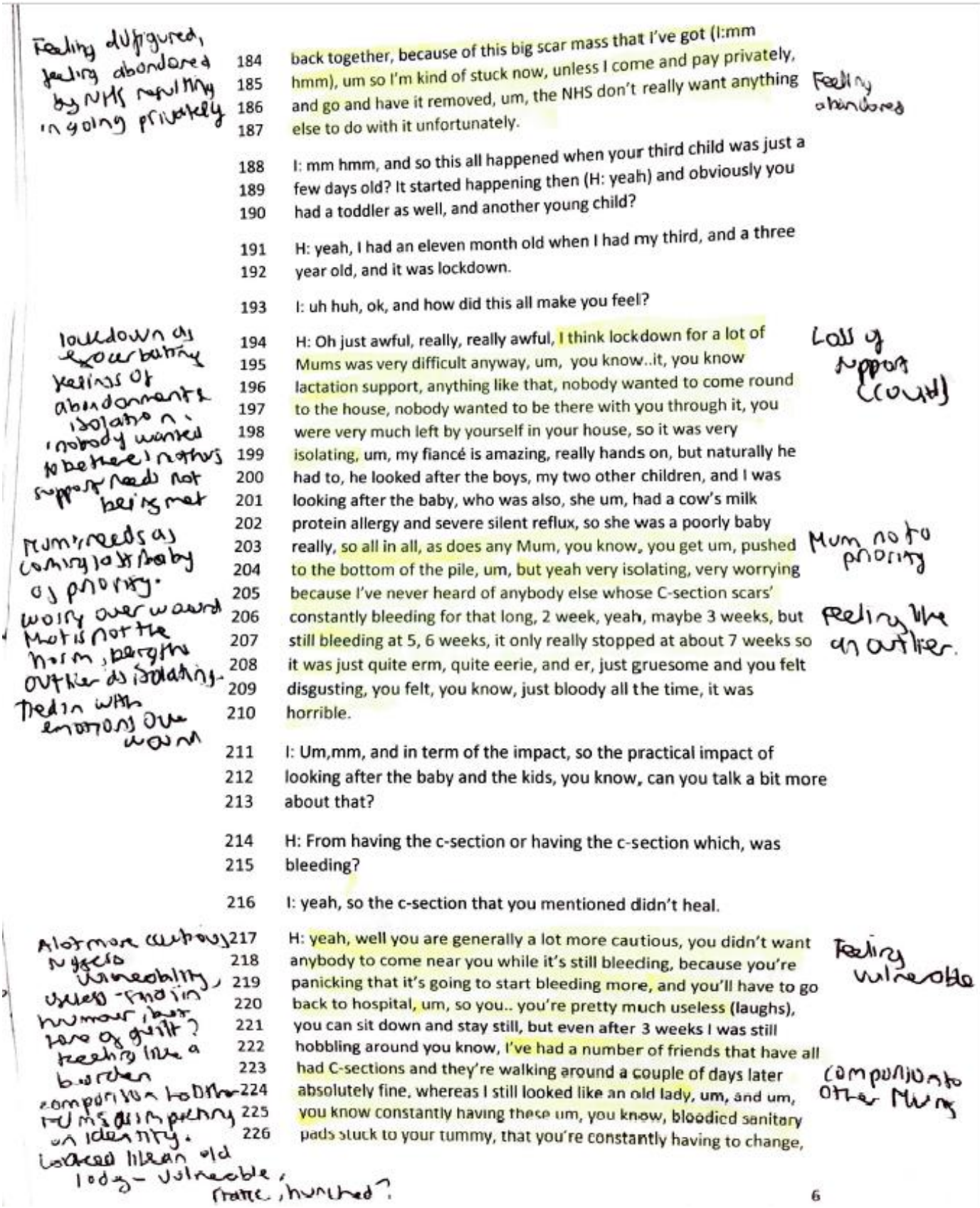

back together, because of this big scar mass that I've got (I:mm
hmm), um so I'm kind of stuck now, unless I come and pay privately,
and go and have it removed, um, the NHS don't really want anything
else to do with it unfortunately.

I: mm hmm, and so this all happened when your third child was just a
few days old? It started happening then (H: yeah) and obviously you
had a toddler as well, and another young child?

H: yeah, I had an eleven month old when I had my third, and a three
year old, and it was lockdown.

I: uh huh, ok, and how did this all make you feel?

H: Oh just awful, really, really awful, I think lockdown for a lot of
Mums was very difficult anyway, um, you know..it, you know
lactation support, anything like that, nobody wanted to come round
to the house, nobody wanted to be there with you through it, you
were very much left by yourself in your house, so it was very
isolating, um, my fiancé is amazing, really hands on, but naturally he
had to, he looked after the boys, my two other children, and I was
looking after the baby, who was also, she um, had a cow's milk
protein allergy and severe silent reflux, so she was a poorly baby
really, so all in all, as does any Mum, you know, you get um, pushed
to the bottom of the pile, um, but yeah very isolating, very worrying
because I've never heard of anybody else whose C-section scars'
constantly bleeding for that long, 2 week, yeah, maybe 3 weeks, but
still bleeding at 5, 6 weeks, it only really stopped at about 7 weeks so
it was just quite erm, quite eerie, and er, just gruesome and you felt
disgusting, you felt, you know, just bloody all the time, it was
horrible.

I: Um,mm, and in term of the impact, so the practical impact of
looking after the baby and the kids, you know, can you talk a bit more
about that?

H: From having the c-section or having the c-section which, was
bleeding?

I: yeah, so the c-section that you mentioned didn't heal.

H: yeah, well you are generally a lot more cautious, you didn't want
anybody to come near you while it's still bleeding, because you're
panicking that it's going to start bleeding more, and you'll have to go
back to hospital, um, so you.. you're pretty much useless (laughs),
you can sit down and stay still, but even after 3 weeks I was still
hobbling around you know, I've had a number of friends that have all
had C-sections and they're walking around a couple of days later
absolutely fine, whereas I still looked like an old lady, um, and um,
you know constantly having these um, you know, bloodied sanitary
pads stuck to your tummy, that you're constantly having to change,

Appendix 10- IPA themes audit trail

10A. Emergent themes listing

Sub themes (#quotes, #participants)

Bodily v medical failing (11q, 4p)

Comparison to other Mums (6q, 3p)

Comparison to social media (1)

Coping strategies/ survival mode/ just get on with it (12q, 3p)

CS as a last resort/ defeated moment (5q, 3p)

CS as clinicians decision (5, 1p)

CS as joint decision (1)

CS as woman’s decision (1)

CS birth as a way of regaining control (2q,1p)

CS due to medical need (4q, 4p)

Dealing with an altered body/ negative body image (11q, 4p)

Family dynamics- other kids/ chores (13q, all)

Feeling abandoned/ lack of interest from HCP (9q, 5p)

Feeling dependent/ like a burden on family (10q, 4p)

Feeling dismissed during Covid-19 (6q, 4p)

Feeling heard/ supported by HCP (5q, 4p)

Feeling isolated/ like an anomaly (5q, 2p)

HCP advice as contradictory (3q, 3p)

HCP communication as one sided (2q, 1p)

HCP undermining wound impact (8q,4p)

Healing as loss of pain/ scar sensations (8q, 5p)

Healing as resumption of normal roles/ activities (8q, 3p)

Healing physical and emotional wounds (7q, 3p)

Impact on role/ Mum identity/ self identity (21q, 5p)

Long term impact of wounded body (4q, 4 p)

Loss of control during CS birth (7q,4p)

Loss of control over postnatal body (11q, 4p)

Loss of control/ social support due to Covid-19 (22, all)

Mismatch in birth expectations (4q, 3p)

Mismatch in postnatal expectations/ feeling unprepared (14q, all)

Mother information seeking/ authoritative knowledge (12q, all)

Mother not being informed by HCP/ kept in the dark (7q, 3p)

Mothers v clinical advice (8q, 4p)

Negotiating control during CS birth (5q, 3p)

Negotiating maternal/ self-identity (6q, 3p)

Negotiating staff care (6q, 3p)

Never ending healing/dealing with an unpredictable body (3q, 3p)

Not being listened to/ taken seriously by HCP (8q, 4p)

Regaining normality (7q, 3p)

Role of family in practical v emotional support (7q, 3p)

Safe delivery trade off (2q, 2p)

Societal views of CS (the easy way out) (7q, 3p)

Touchpoints/ how things could have been different (10, 4p)

Woman as clinical property (3q,2p)

Womans lack of understanding of prognosis (3q, 3p)

Womens informational/ support needs (12q, 5p)

Wounded body (9q, 5p)

Appendix 10B- emergent theme quote analysis

Charlotte Amanda Sarah Maura Tina Harriet Lisa

Evidence	Location	Sub theme	
‘I could have gone down the VBAC route again or I could have had a planned Caesarean, and then all the pandemic things were happening, the height of making decisions was just after Christmas, when all of the pandemic restrictions with visiting and how long your partner could be there. So I did get quite anxious about that time.’	P3, 52-57	Loss of control/ social support (Covid-19, CS birth)	
‘So that was, you know, going to appointments on your own was really difficult for lots of reasons, erm.. yeah the kind of not seeing.. you know.. before Covid, you would have.. phone appointments weren’t an option, I would have seen that Doctor the first day that I rang up for them to look at.. To see that wound, erm, so yeah that was a bit of a delay because of that’	P7, 266-272		
‘I don’t know whether Covid had an impact on the way women are listened to, you know during birth… I don’t think it helps because you’re on your own’	P8, 272-274		
‘, but it was a lot of doing things on your own, a lot of being told lots of information, ermm.. and I think those times.. whether it’s a partner, a friend , or somebody you need that person there to almost talk through what you’re deciding on, not that they’re necessarily making a decision for you, but you can talk about it with them and then.. not phoning them in a bit going ‘well, they said this, and then you can come again at 12 if I’m’, it was almost a bit like that as well..’	P282-289		
‘.. I mean the children too, I mean they couldn’t come to hospital to visit their baby brother, they had to wait like..you know, it’s a big thing, they’re eight and nearly ten at the time, you’re bringing this whole new little person in to their lives and yeah they have to wait to meet their little brother, they can’t come to the hospital, it’s like doing it on facetime, it’s all very.. At the pandemic they spent their lives	P11, 453-461		

having to communicate with relatives on facetime for nearly a year, and now they've got a virtual baby brother'			
''I then had a scan, I think it was supposed to be like 6months later but I believe it was about 8 months later, erm, due to like the, you know, the lockdown restrictions'	P4, 87-90		
'And she said- looking at this no, I don't think so, I think the baby is too stuck. Umm, but you can try, but I don't think that's gonna happen for you. I don't think you can have a natural birth (I: mm), umm, so I was obviously quite upset about that and it was in the middle of still the pandemic, so I couldn't.. my husband wasn't there,'	P3, 56-61		
so in a way, lockdown.. I almost.. I just.. I took a step back and just enjoyed it, so I slept when I needed to sleep, and slept when he slept, and I kind of, you'll probably never have an experience like this with another baby so just enjoy, no pressure to see anybody, or do anything (I:ok), because the only thing I could do was go to the supermarket (laughs).	P14, 543-549		
I suppose when he was born and it was lockdown and everything else I just.. I was just a bit like well.. you either give into this and accept this was of life, or you fight it and drive yourself nuts (I:mm), you know, just.. Just sit back and enjoy it for what it is, it's wonderful, and you know, it's taken us such a long time to get there (I:mm), that.. you know.. yeah I kind of just accepted it, and it was lovely, you know, I just really… I lounged about like most nights I wasn't showering until (husband) finished work, maybe 7 half 7 that evening, but I was like- huh fine (laughs).	P15, 566-575		
and because nowhere was open, and it was obviously, you know, he was born in September, so as things went on it was getting colder and colder, so I was breastfeeding my new baby in the park (laughs), there was nowhere to go and sit, so I think it felt like I better feed him, then he might do a dirty nappy, and I remember thinking at the time- everybody was at work, and because of Covid my	P17, 623-631		

husband was shielding you had to be really careful, (I:mm), so I think I did feel quite alone.	P19, 759-763		
The fact that a lot of it was telephone or online, and it being my first baby, and an unexpected section, I didn't feel supported, anytime I saw somebody face to face, bar the GP, they were lovely (I:mm hmm), but I didn't.. I felt like I needed more support.	P20, 783-785		
and I did definitely feel like I was navigating it alone because so much was handled often online or over telephone anyway.	P20, 789-791		
'but the midwives having no capacity to see me again (I:mm mm), so you were kind of just left.. er, you know, kind of a bit.. out in the open.'	P21, 829-832		
and I was really desperate to see the health, um, the health worker, um.. I.. I was desperate to see her face to face but she was just like- I'm sorry, we'll do a video call.	P21, 835-838		
so I.. again, that was just.. showing her the wound and breastfeeding on camera, it didn't.. it didn't feel nice? (I:mm), it just, it felt a bit like… it just didn't feel nice.	P3, 55-63		
the process was ok, um, obviously it was beginning of lockdown as well, (I:ok), yeah, so my husband was there, um, for 2 hours I believe (I: yeah),um and then he was asked to leave (I:ok), again this was purely because they were limiting the amount of visitors, um (I: yeah) in and out of hospital, um.. so.. um.. obviously I had the recovery bit, which was ok as well, but then the only issue I had was when I went on the ward, um, obviously when (husband) left, my husband, when he left, obviously you're in pain, and um, baby was like, was drinking milk for God knows how long'	P4, 111-115		
. 'cos of Covid, so I was on my own and (husband) wasn't allowed on the ward (I:mm), and um.. so it was a bit hard really (I:ok), obviously you need the support of your family, isn't it? But you were not getting that?			

), and because of lockdown so my husband was home more, so um.. Which was really helpful,	P8, 174-175		
I mean, my side of the family, they are all back home, so it didn't affect me, um, but my husband's side of the family.. obviously we talked on um, Wassap, um, video call and stuff, but um, I think it's because we all accepted that it is what it is, like we couldn't do anything about it anyways (I: mm), so yeah, so we.. so we just go with the flow (laughs).	P9, 312-319		
, I think lockdown for a lot of Mums was very difficult anyway, um, you know..it, you know lactation support, anything like that, nobody wanted to come round to the house, nobody wanted to be there with you through it, you were very much left by yourself in your house, so it was very isolating,	P6, 194-199		
well it pushed my fiancé to be a lot more hands on than probably he might have been, um, he was working from home because of lockdown, so I know a lot of people say bad things about lockdown, and there was a lot of bad things about lockdown, but for us and the way that it happened, it was a good job that he didn't have to travel down to London you know, 3 nights a week.	P8, 278-284		
but all the weighing clinics, or anything like that, they weren't running, because of lockdown, so you didn't even know- is my baby putting on weight? Is she losing weight? You know, you're just um, you're worried about baby stuff as well, um, so you kind of forget about yourself in a way.	P15, 560-564		
'because part of the reason for having the home birth was because of Covid and we've been separated the whole time, it was not pleasant'	P3, 51-53		
Another reason I didn't want the Caesarean was because um, it very quick… very quickly transpired that um, (wife) would not be allowed to go in with me	P4, 92-94		

A lot of the trickiness was even when I was really struggling, emotionally and physically, um, because of lockdown we couldn't have any support, so I couldn't have anyone in the house, um, my parents were our, kind of our support.. bubble. and fortunately at that point she was still working from home, apart from occasional meetings, um, but at that point I was still struggling, I couldn't get up or down with her very easily, and you know, and I was still struggling with.. Well, I was just on my own (laughs), um, so it was really, there were points where because (wife) was in the house, I was like can you.. just yelled for her if I really needed a hand, um, um, but if she had been in an office, or if she had been going into the office, I would have been… stuffed basically. I wasn't trying to be.. cavalier with her, you know, because she was fine, so, it was only that kind of sudden turn of things I felt like that was completely gone, the, er, not being able to just kind of.. kind of, transition from that into a- ok, we're having an operation now, or even just into, things like seeing her being born, and you know.	P14, 600-604 P17, 729-737 P21, 910-912 P22, 948-951		
'the plan was to go for the planned caesarean erm to hopefully make it a less traumatic experience, have more control about what's happening, a bit more preparation,' 'I had a bit of um, CBT therapy because of the like stress and anxiety with regarding for all the birth and that carried on a little bit after, so I did some work around actually saying, like when the Doctors say it's not an IG and I go' ok yeah sure' but you know it's not an [], it was her making me say 'no' you need to kind of say 'no, I know it's..' and be a bit more.. Direct and forceful with asking and keep going, don't just accept it and then leave it for another two weeks.. So, I was persistent basically, whereas I don't think ten years ago a ten year younger me would have done that.'	P3, 61-63 P15, 587-596	Regaining control (CS birth)	

'Given a lot more choices if I wanted to carry on naturally or not..and in that time I wanted to carry on naturally, but it got to a point where.. I just think I have babies that get stuck and don't want to..' 'I think I was given a lot more information as well and was supported to go naturally, which I think a lot of women would want to do that and would rather have that, that option, 'cos especially with the recovery of a C-Section. erm, but I tried that route and that didn't quite work out so we went back to a C-Section' 'I just wanted a Caesarean… I don't think I would have preferred that, it was more a 'I can't'.. it was a not.. I didn't feel able to carry on any longer and I knew it was going to end in a Caesarean once they like, did a scan to see which way he was positioned and, there just didn't seem like there was a good chance of him coming out naturally, um, so it was more a defeated moment I think [I:ok], just get him here and have a Caesarean.' 'I was just getting more stressed out and more upset, and crying about it, and I just said- you know what, just do the C-section because I just.. I don't know, you know it's like I've been there in the hospital for like 4 days now, and at that stage, I just felt worn down by them, er you're always scared, in the back of your mind when you've had a c-section already, like maybe it will be too hard, maybe I can't do it, and when the Doctors aren't really believing you, it makes it really hard, like if you don't have that.. That.. Self-belief in yourself at that moment.'	P3, 65-68 P4, 85-90 P4, 98-105 P4, 134-142 P3, 87-90	CS as a last resort/ defeated moment	

'so they, they thought then the cord is stuck around his neck, which had probably happened when they tried to turn him (I: mm), so it was then a- we have to do an emergency caesarean section. Today.'			
'. So I think it's classed as an emergency because it wasn't planned, but it wasn't like… they have different categories don't they? [I: yeah]. So it wasn't like, someone was in an immediate.. like in a really bad place, it was babies not coming and we're going for a caesarean, and that's what I asked for, so that's what happened.'	P3, 70-75	CS as woman's decision	
'I planed the C-section with my latest child due to there being major complications, erm, in the first pregnancy and birth' and then she said- I'm sorry, we can't.. we can't move the baby. The other consultant was right, the pelvis is extremely stuck, um, you're going to have to have an emer.. a caesarean section, we'll do it next week, um, 'cos the baby's heartrate and everything seems fine um, because obviously I had a Caesarean um, 6 years ago (I: ok), so it was the safest option for me, um last year , um they said we want you to have a c-section because of the chances of rupturing during your third labour with it not healing correctly, so that's fine, 'my daughter turned breech when I was 36 weeks pregnant, um, we had er, we tried to turn her with an ECV, um, procedure, which we did, er, but then unfortunately she turned back again, um, at that point there were discussions around whether to have an elective Caesarean'	P2, 39-41 P3, 69-74 P3, 53-54 P4, 121-123 P3, 38-42	CS due to a medical need	
'The first one was, because I was 19, I was very young, I didn't really understand what was going on, I didn't really understand what a caesarean meant, and where	P2, 55-62	Woman as clinical property	

they, erm, I was in early labour, but they kept me in because my baby was quite large, and they started you know, fiddling with me, breaking my waters, putting me on erm.. hormone drips and the epidural, and basically I just never dilated past 1 and a half centimetres over 2 days'			
'When I went to the operating theatre, the guy said, the anaesthetist said- because you're so large, I need to put another cannula in your arm, and I hate cannulas it's just horrible, you know ohh it's just horrible, and he couldn't find the vein, so he literally put 4 cannulas in both my arms, and I was just like at the end I was like- please can you stop, because this is just horrible, and he was like- no, no, you know, I need another one. And I had to beg him to take it from my arm, because I know that's never good just staying there..Anyway, he ended up getting it from the arm, and then he.. when I.. because I had to lay.. Because it was in my arms, they needed both my arms to do like observations on so I was literally laying with my arms out in these stilt sort of things, and then um, it was just a horrible experience to be honest, I just hated it, I don't really think about it because I get upset,'	P5, 164-178		
and she couldn't do it right, and it hurt a lot, and she was doing it –uh, uh (miming jabbing movements), and I was like, I was gripping the bed, tears were just.. it was very painful, the way she was doing it, because obviously she hadn't done it a lot, I don't think that had helped, so that set me up, just remembering all these thoughts now, that set me up during the operation thinking- oh God, like, had a trainee doing it, are there other good.. you know, is there other good trainees going to be doing it? Um doing other parts of it, and it..that worried me, because I remember my fiancé being, you know, looking at me like- are you ok, and I was like- you know, gripping, in absolute agony, while she was doing it- oops, sorry, yep, oops, I'll just try again love, la la la..	P9, 333-344		
and the next thing I know I was being read things, signing forms, being given (sighs), being given er, injections to stop my contractions, which I don't.. I may have been told about, but don't remember having a warning of that, that was it, it was just done,	P5, 162-166		

and then this MCA who didn't introduce herself, just kind of barged in, woke me up and was like- Hi, right, I'm going to take your catheter out, and I was thinking who the hell are you and what's going on? You know, no kind of preamble and having been told one thing and she was doing something else	P11, 440-444		
, 'I was crying my eyes out to be honest, because I think caesareans are awful, and I don't really know why Doctors are so eager to get you in for a caesarean to be honest.' 'Basically at every turn the Doctors were like to me (deepens voice)- you need to think about a c-section , you need to think about a c-section, and remember there's nothing wrong, there's nothing going wrong, the baby is healthy, I'm healthy, you know I'm just quite.. Uncomfortable, I'm in a lot of pain, but everything is fine, so I don't understand why they were pushing for it so much. They just kept, it just felt like they was bullying me, and I kept trying to fight my corner saying I can do this' and then the next day, you know a new Doctor comes in, at like 8 AM it's new midwifes and new Doctors, and um, again a new Doctor comes and she's like ' you know, um, because of your history with a big baby you should really be thinking about a c-section', and I just looked at her and I was like 'I don't see like, there's no medical emergency for me to be having a caesarean, you know, I want to do this'. 'For the Doctors that cut you open I suppose, I feel like they see it as just another day in the office, and it's like um.. it's very logical, it's very dismissive, it's very cold, it's a cold atmosphere (I: yep), and.. When it's the birth of your child it's supposed to beautiful, it's supposed to be.. You know, exciting, even if it has to be a caesarean, it should feel different, but..It's just a cold environment and that I feel could help greatly for someone to not feel as bad about the experience.' now if I get pregnant again they are going to push me hard to have another caesarean because I've had two, and they don't really agree with you having a VBAC	P2, 46-48 P3, 93-101 P15, 620-628 P17, 681-686	CS as clinicians decision	

after.. So.. I know now, I have a fear that if I get pregnant again, I know the kind of.. I know how much fight I'm going to have to give to get what I want .. 'the consultant convinced me to book an elective, she said- ok, go home and try to go into labour naturally, but if you haven't gone into labour, I'd like you to book a Caesarean'. they were respectful of my choices, but I could tell that.. Consultants are risk averse, and they wanted us to have a Caesarean because that's more.. Comfortable for them.. Familiar kind of routine when babies are breached, so they were kind of trying to convince me to have a Caesarean, and I was like- she's fine, like we're monitoring her, she's fine, if it changes obviously that will be different, but let's just see how things go, and the agreement was.	P3, 63-65 P3, 67-70 P4, 122-125		
um she said you can birth naturally if you want, but I think ultimately it is going to end up in an emergency scenario, um, so.. obviously with that my husband and I made the decision we would go for the planned caesarean	P3, 74-77	CS as a joint decision	
'I think the planned [Cesarean] still would have been the better option, I could have done that but I didn't have that choice as soon as I got to hospital after my waters breaking, I was asked if I wanted to then, but.. ' and when I was waiting in (hospital name), my VBAC team was there, and I just, I didn't really realise you know when the head of midwifery came to me and said- look, we don't have any beds for you, it's manic, but you can go to (name of another hospital), and I just said 'yeah, ok I'll go there', but I guess, I just didn't really realise,um, you know how it will be at the time, Well I mean, if, for example, if the Doctors.. if the Doctors haven't had.. You know, if they hadn't been more prone to doing caesareans and wanting um.. To help along the situation for a vaginal birth to happen, a lot of this may not have happened	P3, 82-84 P15, 609-612	Touchpoints/ How things could have been different	

so come day 3, um, when the Doctors checked it like obviously I could smell it, smelled like really ugh (makes a disgusted noise), ok, just terrible, and obviously like, in my opinion, like, if like , if like they did have a look at it and rinsed it, or do whatever they were meant to be doing, then it wouldn't be that way?	P3, 76-81		
and it was very hard to reach the decision on that, whether I should go ahead with that or not, um, because nobody would tell me what to do, it was very much like- whatever you want to do! And I thought- aah! I don't.. I don't know, what's the right way? What's the wrong way?	P3, 43-48		
so I do regret having a C-section with my second, because then.. If I had gone natu.. vaginal birth with my second, I could have had a vaginal birth with my third and everything would have been fine..	P8, 304-307		
I try not to have any regrets in life, but that is one of them, that's..I regret that decision, um, but you know, who knows, it might have ended up in an emergency c-section you never know, or I might have had a worse tear, or whatever, you can't, you can't decide these things, you know, how these things happen.	P8, 309-314		
And in hindsight now I should have said, no, I don't want a trainee doing, going anywhere near that area of my body, I want you to do it, and I should have um, I shouldn't have been as easy going and I am quite an easy going character and I tend to go with the flow and think –oh yeah, everything's fine, but looking back, I should have said no way Jose, anybody else.	P9, 328-333		
I didn't have the chance to not have a C-section because of how close I had those two babies, so.. even if.. I had you know, read something about somebody who'd you know.. I'd just..I'd probably would have thought- well there's no point dwelling on that, because I have to have it, so let's not scare myself prior to me having it, if it happens it happens, it's shipped.	P18, 714-719 P21, 827-829		

, because I do think C-sections are necessary for some people and I felt at the time that not was necessary for me, um, hindsight's a wonderful thing isn't it			
'at that point I'd had an epidural, that didn't.. they didn't switch the machine on properly so that wasn't working, the baby was back to back, I've been on the hormone drip so the contractions were.. and this had gone on from midday on the Saturday and now we're at about three Am on the Monday morning' 'so.. the original scar.. C-section wound is that 10 year old one, I always had that tight, so it's almost like you get where the skin goes in and you get that lumpy overhang bit. I have friends that don't have.. you know they had C-sections and they've not got that, so I don't know if it's just the way I was stitched up or the way my body heals, but it has always been very tight, um, with a lot of scar tissue around it anyway, erm and quite a long one.. When I had it it's pretty much from hip to hip, I think it was quite.. I think my first one was quite difficult to get out so they needed a bit more room to get him out.' 'I think there's a lot of people that, like I did, still do, think that childbirth couldn't.. Shouldn't go this way, and maybe.. I think there's sometimes too much intervention, too early, and then.. Like your body the way it's shape, like different pelvises, I've learnt since about different shaped pelvises and how they are in the body, and there's very many factors that I didn't understand, you know, it's not just as easy as you go into labour and the baby is just going to come on out, it's very much like.. I think some people are quite, you know.. their bodies work that way and things go smoothly and I think some people, it doesn't work out for..'	P4, 93-98 P5, 167- 176 P15, 620-630	Bodily v clinical failing/ self blame vs clinical blame	

Ok, so it wasn't planned, it wasn't planned..I was trying for VBAC which is a vaginal birth after caesarean, well, it just, it didn't happen, because the erm, they tried to use a form of induction on me, without hormones and er, it didn't work, so they did a Caesarean.	P2, 39-43		
we were waiting for 2 or 3 days, 3 days I think, to be seen, to be induced. And the reason why I wanted to be induced, even though I know it lowers my erm.. Possibility of having a VBAC, is because I was in a lot of pain, I had erm, STVs and it was so bad that like sleeping.. You know I couldn't even walk, and I was knakered because my second son, who I have now, he was a lot bigger than my first, and I didn't know at the time but you know, that must have been the reason I was in a lot more pain	P3, 77-85		
'They put these rods inside the cervix to try and dilate it manually (I: mm hmm), and my cervix is very far back, and it's tilted, which whether I'm pregnant or not makes it hard to find, and erm, they were having issues finding it, and even then the Doctor was saying 'you should really be thinking about a caesarean', and I was like 'well no, just do your job and find it, you know, it can't be that difficult',	P3, 105-111		
and I found out that they had to cut me longer because there was so much scar tissue from my last caesarean that they had trouble getting through, so..I think the reason why it was so much more painful, was because they literally cut me a lot, a lot bigger, it was like kind of from hip to hip you know, like that length, instead of just half,	P5, 192-197		
' when they went in to get the baby out, erm, they then, er, took longer than they predicted to perform the surgery due to there being damage inside so they struggled to stitch me back up, erm, because there was damage from the previous birth, so I was in there about 45 minutes longer than they anticipate the usual planned c-section, erm, they also then had to put a blood drainage in, erm, because there was like built up blood or something inside'.	P2, 45-52		

so the next day I went in for my scan and actually it was the same doctor scanning me who had done my 12 week scan, and.. they had said to me from about 32 weeks that um, the baby was, the baby's head was very engaged (I: mm) for um, a first time Mother, they were saying - oh, it's unusual, and you know at all the different midwives, and then when I went for the scan on the Monday at 38 weeks, the consultant said to me the baby (M; laughs slightly), the baby's head is not engaged (I: mm), the baby's pel.. It's the baby's pelvis, the baby is stuck. so that by the end of the pregnancy I was over 19 stone, so I was very large, very uncomfortable, had pelvic girdle pain, suffered really horrendous morning sickness, along with having a newborn baby, was just a nightmare, um, and um, my c-section scar essentially didn't really have a proper time to heal (I:mm), so you know, 2 and a half months after the operation, it's all of a sudden getting stretched again I guess. I think my healing was pretty bad because I reacted badly to the epidural, spinal block, whatever it was I had, um, and I know that's not normal, because they really have to move a lot faster, and you know, root around a lot more, particularly with having breech, you know	P 3, 45-53 P4, 113-119 P20, 809-811 P17, 718-720		
'because of what happened before I had done a lot more.. Research and there was ten years between the two C-Sections, so.. erm.. I've heard a lot of questions that I had and I've been back to like when they go through your birth notes and go through different things, so I think I got this time a lot more informed' 'So I was induced with him, um, I don't think that helps at all, I think that pushes C-Sections, when you.. When I speak to friends and things that I have read, I think that doesn't help the situation, that they just haven't had the time to get naturally	P4, 110-115 P4, 122-129	Mother information seeking/ authoritative knowledge	

into the positions and things that they need to be, erm..and positioning definitely seems to be a problem for me.. so maybe that didn't help, and it was the not having any information before about what would happen if you know.'			
', I don't think that a lot has changed from both experiences, like from this one to ten years ago, it's only 'cos I had the one ten years ago that I knew more what to expect, what to maybe ask, what to look up on google, a lot of that has given me my information is things online.'	P13, 503-507		
', well you end up googling stuff (laughs), you go to Dr google'	P15, 586-587		
'I didn't know at the time, you know, doing certain things, walking around, moving in different positions would have helped me to dilate'	P2, 62-64		
'when they came and bought the forms I just laughed, because all these Doctors have been saying was 'you can rupture, you know and the rate of rupturing was like maybe 1%, or you know, 1.3%, that's.. That's.. tiny, or you can get shoulder dystopia, which is an even smaller percentage. And then when they bought the c-section forms it was like you can die, blood loss, haemorrhage, we can cut open an organ, there was like 10 things that they had to take me through of risks compared to the 2 risks of a VBAC, and I just thought- this is ridiculous, you should be more determined to help a woman have a baby naturally'.	P4, 148-157		
'so it was like a service I found online, I was just typing in like anxiety from like traumatic births, and then going on to having another, so I emailed them a few times, erm over email and it was like a support service, and I just made a self-referral, um, so I spoke to them and I read like stories on their website'	P18, 744-748		
actually looking after the baby, none of that fussed me, getting up in the night, none of that bothers me, I'm quite.. I'm quite laidback, and a lot of my good friends have had kids, and you know, I'm Godmother for other babies, so I was..I wasn't not prepared for.. you know, hard it could be at times,	P14, 524-529		

my best friend said to me when I was pregnant- I'm worried about you giving birth and trying to do it all (I: mm), and I said- are you? And she was like- yeah, and she was you know.. she was like you know, you're really got to, um, put no pressure on yourself, you know, and as long as the baby's clean and fed, don't worry about anything else (I: yep), she um, she had 2 kids at that stage, and I think that probably stuck with me, because I hadn't thought about my.. I hadn't thought about myself postnataly,	P15, 597-605		
and she would say- look I'm not a midwife, and I'd think, well forget about it for a minute from an obs and gynea point of view, just look at it from a wound.. point of view, of which she has plenty experience, so she did.. but, yeah, it just, it just made you feel a bit on your own.	P20, 799-803		
'apart from the smell, I had the same experience with my first one? So I was kind of like expected, um, you know, expected to be in bed for a while and not being able to do what I normally do.. so um.. yeah.'	P6, 165-168		
so I browsed a fair amount of information on the internet, and.. what else? I think that's it, and then, oh! And then, me and my husband we talk to each other and obviously we if we didn't know.. If I didn't know anything then he'll have an idea, or.. yeah.. I guess we just rolled with it.	364-369		
I was looking on google, on forums (I: uh huh, ok), but a) they're just quite erm, quite a lot of scaremongering isn't it? A lot of people saying you know. horrendous things that have happened to them, where they've nearly died and things, so.. I tried not to look at them too much, um, but yeah I found it useful on google a lot, trying to find a little bit of reassurance that it did stop at some point, um.. but yeah, it's not.. not very good.	P13, 530-536		
	P17, 715-718		

so that really helped to have her personal perspective, because we got on really well with her, and it was kind of reassuring that.. to still feel pain you know, in a year or more later, wasn't unheard of			
'with the original C-Section ten years ago it was very much the conversations that you have with midwives and professionals were ' if you have a caesarean it will'.. you know….'. it should be very easy to labour naturally, and it almost feels like a failure side to it that if you haven't been able to do it, then you've done wrong rather than.. and not understanding all the different things that can go along the way.' '.. I mean what the surgery is, I don't think people understand like how… What the surgery actually involves and why you're going to struggle after, and actually why it's important not to do too much too soon, and how that can impact on the healing and how you're feeling.. Erm, and I also think.. There's also that feeling of erm… The c-section.. You've had the easy way out? You haven't given birth vaginally, but actually, I'm not sure it is necessarily the easy way out because of what… I think that's what people don't understand, yes, it is a horrendous experience either way, but if people maybe knew more about what the surgery involved then they might not be so quick to think' oh, you've had a c-section, you're ok and can get on with it now'' 'I don't get it, I don't get how you, you know, if I had an operation for something else and had to go back having it you know, checked out, and have a wound looked at a later date, I think there would be a lot more around.. You know, has it healed, has the operation.. Has it gone as expected, that's what it is, if you had a planned operation and you had a follow-up appointment, you're checking, you know.. you have this problem, do you still have this problem? Has it healed? You know, what are the next steps with it, there is no follow up, there is no after care.' 'You know, the thing is you don't really feel heard when you say about caesarean, because for some reason people seem to think it's the easy way out, or- oh, it's so much better that you had a C-section because your baby was so big, you know you must be so happy, and it's like well.. You know the Doctors were saying that when I	P4, 115-122 P13, 516-527 P16, 653-662 P6, 250-260	Societal views of CS/ The easy way out	

was going to the Doctors surgery saying that I was upset about it, they was saying- Oh no, Doctors don't do it for no reason, you know there must have been a reason, it's what's best for you, bla, bla, bla' I think for one that the Doctors.. You know, that the staff in general need to think differently when it comes to Caesareans, um, I think that they need to understand that it shouldn't just be a thing of- oh, just have a caesarean. I really believe it should only be in emergencies, that that should be used, and um, and they should really try and help women really not have to go through major surgery, to then look after a newborn because it's hard work,'	P15, 588-595		
'maybe it's because it was planned so they didn't think those things are traumatic, I don't know, but yeah, there was nothing like that, it was completely different in terms of support when I had my daughter.'	P17, 694-697		
I just feel a bit like.. just because it wasn't an emergency c-section, doesn't mean that it's not traumatic in other ways (I: mm, yeah), you know, like, as in terms of like the healing, infection, or.. You know, being discharged after you come out of hospital, all of these things, it doesn't take away the trauma or how you feel, as like a Mum (I: mm hmm), you know, being like debilitated or whatever the words is, do you know what I mean? Like from being able to do your job, that still causes trauma, but I think the reason they didn't do all those things is because it was a planned C-section if 'm honest, thinking about it now, um, that they probably have those service for people who have emergency c-sections, but the manner in which.. you know, infections, and going back to hospital and pain and stuff like that, it doesn't take it away from it being traumatic, so they probably should look at more specifically the context of the labour you know, because even people that have like natural births, they may have a traumatic experience and they're getting overlooked too, you know?	P18, 707-717		
and people talking about births and people just assuming that it's a vaginal birth, you know, um, I know some people actively choose to have a Caesarean um, but particularly for people for whom it's been tricky, and you know, is.. just the way	P23, 983-988		

people talk about birth, um, how there's an assumption that it looks a certain way, just really, doesn't help			
'I know some ladies don't like a lot of information, they rather go in blind, but, I think a lot of women would rather know if it goes to a C-Section, this is kind of what would happen. There's such a lot of noise and then you're in a theatre, and there's lot so of stuff going on in the theatre, and you're very clueless and then to be put to sleep and then you wake up and you've got a baby, its just.. kind of mindboggling if you like…It's hard to get your head around that.. for years after.' 'When it was all said and done I didn't get skin-on-skin with my baby again, they didn't even offer it, um..and I didn't even get to hold him for about an hour and a half, but he was next to me in the cot, and I was like, please can I hold him? And they just said- no, we need to do observations. And I was like- I'm fine, just let me hold him, because they were waiting for a nurse, but they just wouldn't listen, they just left me there' ''so I was like- what's happening? You know? starting to get into a bit of panic, but they did sedate me so it wasn't you know, erm, in my mind it was more of a panic than like my body panicking, but I was just sort of asking like ' why is it taking so long?', erm 'what's happening?', erm, but at the time, one of the people in the surgery was like 'we're just having some difficulty, but everything's fine, it's just taking longer' and that was all they said.' , I was just worried, because of my first birth more so, um, in my first birth my daughter was taken, I didn't see her, she was taken straight to the ICU, so it was like, I was having a bit of like PTSD, of like 'what's happening', 'what's wrong with the baby', 'what's wrong with me', so I started to get a bit worried and going to like a worst case scenario,	P5, 178-185 P4, 115-122 P5, 134-139	Loss of control (CS birth)	

'and they said to us- you know um, your baby has likely gone into a lot of shock and it does need some attention, so don't be alarmed, if you don't hear a cry and I remember feeling really, really frightened then'	P5, 139-142		
I think I was so pressed for a natural birth and I was so hell bent, I was going to do this myself, no drugs, you know, I was really keen for a midwife led birth in the midwife centre in the hospital, you know, birthing pool, I had a.. you know, I had home um, you know the dilator kits, I was doing a um, you know, hypnobirthing, um, so, when they had said that I was going to have to have section, I bawled for an entire night, I was so upset, um, I felt ready and I felt excited, you know, for a natural birth (I: yep, yep), um.. so then when I got over that and then obviously the whole thing of it having to be an emergency, like I said you just kick in to well, all you want is for your baby to be safe,	P13, 489-500		
I was ok, and then I rang my husband because he was obviously, he couldn't be in there, he couldn't be in the hospital, um, I rang him and I burst into tears, I think the reality almost kind of took over, and.. um.. and then I was ok Clemmie, I suppose it just happens, doesn't it? You go- ok it's happening. The main thing is my baby is ok, that's all I care about (I: yeah), you know it's just happening today, and then to be honest I felt really energised	P4, 98-104		
so I spent the Saturday (laughs) absolutely, inconsolably in tears all day, like- I just want to go into labour, I don't want a Caesarean, I just want to have my baby naturally, I don't want a baby extraction, just felt like booking you know, to have your teeth taken out or something, it just didn't feel right for me.	P4,111-116		
basically my body was just in medical shock, my whole body was just shaking (I:mm), I couldn't.. Couldn't kind of bring myself back, so it was really an out of body experience, it was like being on drugs or drunk or something	P5, 173-176 P6, 190-194		

. I kept saying- I want the screen down, I want the screen down, as soon as possible, I want to see her being born, and they put it down, but she was already out, and that's been a real.. I mean they did explain to me at my birth reflections appointments that that's probably because she was breech			
'So as much as it was very awkward and I was under , you know, had lots of tubey things in and out of every arm and everywhere, that she was able to get him to me, so I felt like I'd had that first contact. I knew where he was, so when they had to put me to sleep, I was ok with going to sleep, because.. I knew he was with my husband, I knew.. I'd seen him, I knew where he was, which was very different to the first experience of .. well.. just waking up and there was a baby, it was almost like is that definitely our baby? I've never seen him [laughs], so there's that loss of connection between.. between.. that's your baby and you've just given birth, so that was very different.' 'I told them look.. With my first caesarean the reason why I hated it as well is because I didn't get to hold my baby, I didn't get skin-on-skin, um.. you know.. Things like that, so I said you know I said if this happens I want skin-on-skin, I want to see my baby you know, I want the drapes pulled down, things like that, and they was like- yeah we can do that, that's fine.' ' I asked them could I go home to get a bag, and just, have a shower and settle myself, um , and the consultant spoke and they said- you seem very calm, you seem together, yes, come back in 2 hours (I: um hmm), so that was fantastic, I came home, I had a shower' 'and I was just really, really calm (I: mm), I had a shower, shaved my legs, er, just finished off a few bits of packing, um, I made him lunch, I made myself lunch.. Oh no, I couldn't eat, I'm sorry that was a lie (I: mm hmm), I couldn't eat because of the surgery, um.. I made him lunch and I just did a bit of cleaning up, and then we got a taxi to the.. We took a nice photo- it was a sunny day, and then we took a taxi to the hospital, and um, I literally went straight up.'	P5, 160-161 P4, 158-164 P4, 105-110 P4, 113-120	Negotiating control (CS birth)	

'from the second they said you're going to have to have a section, I felt out of control, but I'm not… I'm not somebody that needs to be in control? I'm not, I've never been like that, you know, but I've always been very independent and I like options (I: mm, yeah), and then I like to make a decision, you know, once I feel like I know the options (I: mm), so I think, having it removed from me, nearly take away your options, you just.. you have to accept it 'cos there just isn't any other option (I:mm mm), um, but.. yes.. the second they said.. yeah, you have to have a section, it did feel that nothing's in my control now at all (I:mm), it's just a matter of keeping myself well and monitoring the baby.' we were talking about vaginal breech birth options, and I did look at some gentle caesarean options, I watched a gentle caesarean video, and I was kind of ok, I could just about be able to do that, so that's that I kind of wanted but I found it really hard to communicate, we tried to be as clear as possible in our birth plan, so I felt able to say my preference in terms of, you know, even though I could tell they just rather I have a caesarean, I, you know.. they were respectful, and I was able to say my preferences and you know,	P17, 693-704 P21, 881-886 P21, 905-908		
'So I've never had this neat, small scar that you saw like in pictures and stuff anyway'	P6, 176-177	Comparison to social media	
I mean it would be nice if I was fully healed now because there's some women who say- Oh, I'm fine, I was walking, I was doing this and that, but I guess everyone is different. I can't even do the basic things that a Mum is supposed to do, like you know, I speak to other mums, and you know, or like family members that have had babies, and they're out of hospital the next day, and they're feeding and changing their babies and stuff like that	P8, 299-302 P6, 186-190 P11, 391-394	Comparison to other Mums	

I would see other Mothers down at the park, and again it was lockdown, you know, so you couldn't, there was no baby groups, there was nothing, and I'd look at them and go how the heck (laughs), they're just flying along I've had a number of friends that have all had C-sections and they're walking around a couple of days later absolutely fine, whereas I still looked like an old lady. my best friend just had a c-section 2 months ago, and you know, I went and saw it on day 5,and I said- oh, let's have a look, and it was just a line (I: mm), and I said- where's all the bruising? Where's all the redness, where's all that? And um, mine just looked like a complete war scene, it looked horrendous. and then I just had a really bad time um, recovering from the C-section wound, whereas, I've probably got 8 friends who've all had a C-section, and none of them have had those issues, also it made me even more disconnected because where I was able to see like our NCT group, they were off and up and about like days after	P6, 222-224 P12, 456-461 P20, 812-815 P16, 660-662		
', and oh.. It sounds horrid, but because it hangs over your like stomach, it's all swollen and everything and hangs over and you've got that wound, it's quite hard to keep it dry like you have shower and bath, well not bath, but a wash, and try to keep it dry, it's quite hard to keep that area not.. not.. moist.. So it was a lot of trying to keep it clean, but the stitches' 'however I think on like day 3 or day 2 they um, the blood drainage became infected, erm so there was a lot of like blood and puss seeping out, erm, and then it kind of came out, you know like the tube, it came out?' , it's absolutely fine, so it (wound) was really large (I:mm hmm), they said it would be around 10 centimetres, I think mine is nearly 17 (I:ok), erm and I had bruising too from my knees to up under my breasts	P6, 182-188 P2, 57-60 P6, 192-194	Wounded body	

they told me to keep the sanitary towel there as well, to absorb, um, because obviously like it was quite sweaty and it was always wet down there (I: mm), so they told me to put the um, sanitary towel there and to keep changing it every now and again (I:mm hmm), um, yeah so to just to keep it dry (I: mm hmm), but apart from that they didn't say anything else really (I:ok), the only thing is it was a nasty smell man (both laugh)	P5, 130-136		
my scar kept haemorrhaging, um, that was quite scary, and kind of gross, you know, to have an open wound that just doesn't stop bleeding for 7 weeks, is disgusting.	P4, 127-130		
just gruesome and you felt disgusting, you felt, you know, just bloody all the time, it was horrible.	P6, 208-210		
well you are generally a lot more cautious, you didn't want anybody to come near you while it's still bleeding, because you're panicking that it's going to start bleeding more, and you'll have to go back to hospital, um, so you.. you're pretty much useless (laughs),	P6, 217-220		
you know constantly having these um, you know, bloodied sanitary pads stuck to your tummy, that you're constantly having to change, um, it, it was awful really, and then you end up bleeding out, bleeding on the sofa and I mean it's just, ugh, really messy and horrible,	P6, 225-229		
despair, um sadness, that it's, you know, why is it happening to me? um, just um, felt dirty because it was just blood all the time, um, just really down in the dumps, and I think if I.. wasn't as strong a character as I am, I would have definitely spiralled into postnatal depression, um, for sure, because it was just harrowing, um, and very worrying, you know, you just felt very fragile,	P7, 237-242		
'when they, um, came to change my dressing and they were like- she was like, wow! The bruising was considerable.'	P13, 521-523		

'on my left hand side and there was a section about 2 inches that just.. the rest of it seemed to be healing quite quickly and the stiches dissolved, then it was a lot easier to wipe it and dry it, but the other side, it just..the stitch wasn't dissolving at all and it was getting all yellow and pussy around the area and it was about.. Yeah..nearly an inch to two inches that weren't quite healing up [I: mm hmm], it was open a little bit and I think the frustration again was having to do with Covid is when.. it was like red around it, you know when, you just know your body don't you? You know it's not right, but you're ringing GPs and it's a telephone appointment, you have to send photographs, and they're like 'oh it looks ok',	P6.188-199	Feeling dismissed (Covid-19)	
'I had two phone calls from home visitors, um like one was putting like phoning for like you know an appointment, and I spoke to her for like 10 minutes, and the next one just rung me randomly out of the blue maybe like a month later, and I was like is that it? Is nobody going to come and see me? And she was like, no were short staffed, erm we don't have anyone.'	P11, 453-459		
'So when I spoke to the lady on the phone I was like um.. You know, there's still pain, the scar itself looks fine, but I'm still in pain, is that normal? And she's like yeah, it's normal, it's fine, um you know, she wasn't concerned to see me or to check that the wound was completely healed, do you know what I mean (I: yeah), um, I just feel like, because of Covid now, they just don't, I mean even now you can't see them face-to-face unless you know, I don't know, you have a proper issue, everything is over the phone now, so it was.. I just felt a bit .. Again it wasn't that great, because it was on the phone and I have.. I have a wound, you know, it doesn't make any sense.'	P12, 493-503		
'and at the 3 week check-up it still wasn't fully healed, it still hadn't fully closed (I:yeah), so when the health visitor… and remember I didn't see the health visitor face to face, that was all online (I: yep), which felt really bizarre, and again just made me feel a bit more , er, isolated, erm, I had to (clears throat) I had to show her my wound online, and I remember feeling a little bit exposed doing that, that almost felt, you know, a bit, it almost felt a bit voyeuristic? You know whereas if	P19, 745-754		

somebody's face to face, you know, they're looking and they can.. they can make a medical observation,' I've been referred to a physio, but she won't even do a video consultation with me, she'll just do a phone call, she's telling me to put my fingers in between my tummy muscles, and what.. and I said I can't, I can't do this over the phone, you know, it's not,..it's not going to work this, um, so yeah, I have reached a bit of a brick wall with er they just really didn't want me there, they didn't want me anywhere near the hospital, they wanted me far away, so I felt very much like I was just.. I did feel very neglected by the NHS during that time, um, and because they weren't getting in contact with me to check if I were ok, I then presumed I was ok, though I obviously wasn't ok because I was getting infections and it wouldn't..	P5, 178-182 P11, 408-414		
but they said they wanna keep an eye on me because of the trauma experienced in the first birth, they wanted to like just keep an extra eye just to make sure my mental health didn't take a turn, and like needing it the bigger I got and the closer I got to the due date, um, so that was helpful, and that was supportive the workup in the.. um, the operating theatre, the team were absolutely amazing (I: mm), the anaesthetist was just so lovely, um, when she was giving me the epidural and the spinal she was just really lovely, and she was like you guys seem really calm, and anyway she asked us our story I said to the midwife I'm still having this searing pain, and she said- oh, that shouldn't be happening now (I:ok, mm hmm), and I said-oh, but it is, and she checked my wound and she said- oh the healing is good but I can see um.. you can still see on my scar now, kind of at one end of it, it.. it wouldn't close, it was still open (I:ok), and she was saying you still have to be careful with that, that's an infection risk, you know da da da, it will close but it's going to take some time, clearly, um, and she was just wondering if in the night when I was doing that stretching was that opening it a little bit.	P15, 574-578 P4, 122-126 P9, 317-326	Feeling heard/ supported by HCP	

: I think one of them hold my hand, and then she said she was trying to do it um, gently, but then again like I said staple in your tummy, it's.. 'cos some of the staples they were like really deep as well? Deep in the skin so obviously they were having a difficult time to er, um to pull it, but they were brilliant (I: mm hmm) um, I must admit, yeah.. the anaesthetist I had for my first c-section with my second child, he was great, he was fantastic, he was very um, calming, he was very professional, he had loads of experience, um I felt very much in safe hands, whereas when I had my second c-section, it was the same anaesthetist, but he had a trainee with him. ..and several times, I, you know, spoke to the doctor when I was..or the health visitor and said this is still bothering me, and they kind of felt that everything looked like it was healing fine and feels line, once or twice I had a slight possible.. I had to have some cream for.. a potential infection, where there was stitches that hadn't been.. that hasn't dissolved properly? And it's got a little bit, there was like a little spot that kind of came up and.. but we were able to kind of treat that, with some anti-fungal cream of whatever it was, antiseptic cream, um, yep.	P12, 414-419 P9, 319-324 P16, 689-697		
'and again it was checked by a health visitor- I've been told it was ok but I knew it wasn't, so it's again another phone call until I managed to get an appointment to go into the surgery, and that stitch was all gunky around it and it hadn't healed up' Because actually when I phoned the GP at the start, when I knew something wasn't right, and it had been prescribed, it might have healed a lot better, and I wouldn't have had the extra month of it not healing, and then maybe the issues that followed from that, it.. yeah.. But..' 'I think a lot of the time you feel like you're over reacting to things? (I:Mmm), like that's what it felt like, you're ringing up and it's 'Oh, well you have just had a baby'	P6, 199-203 P7, P243-247 P14, 566-571	Mothers knowledge (intuitive/ past experience) vs Clinical advice	

it's that kind of you feel like you're over-reacting when actually you know there's something not right.' 'Yeah…It's the professional telling me that's what it is, but I knew it wasn't right so.. and then again that's an experience thing, 'cos I had a c-section before.' I think because I can compare the two, my last one which I thought was painful enough, but this just took the cricket really, so for me I just felt like- well this is a lot worse, but they just said it's fine, give yourself 6 weeks to heal. 'so like when I packed for my son they were like- why are you packing so much? You're having a planned C-section, and I was like- well, you never know, what can happen, because of what happened in the first time, you know, I just felt like, let me just over pack and actually I still needed things brought in to be honest (laughs)' I just over packed because I thought- no, because the first time I packed for like how they advise you to pack, and I needed so much extra stuff because I stayed in hospital for so much longer. : first time that I noticed that it was going all black and gooey (I:mm), I was like- that doesn't look right, um, like I've got a picture of um, of my, of the area, and it's all black and red, it looks horrendous	P15, 598-600 P7, 269-273 P15, 586-591 P15, 593-595 P12, 454-456		
'And then, I think it was like 2 or 3 days after that.. so a good week later they called again and said they found another bacteria… So I don't know why they didn't find it all in one go? Like they just seemed to they discovered that there was another bacteria on the swabs, so I think I had another lot of antibiotics then, and then eventually it did start to heal up but it's still a very tight scar'.	P6, 214-220 P3, 79-82	Woman's Lack of understanding of prognosis	

‘. Erm, they gave me medication but they said I had caught pneumonia? So I don’t know if that was related, they said suspected pneumonia but they weren’t sure. They run some test and stuff and gave me medication’ they put me on like high doses of pain killers so I was like in and out of sleep, um, and then like the next day, they came and they said like we have got a complete diagnosis, but it’s suspected pneumonia because they picked up something in my lungs or something, erm but it was really scary and it was really confusing’ ‘It was just a really strange experience, because I mean I had pneumonia when I was a child but I don’t remember, and I don’t imagine pneumonia to be like bodily pain like that I wouldn’t know how to help the healing better because no ones.. no one’s ever told me (I:mm), so if I knew now, if there was a better way of healing, I would have done that, but.. I still am in the dark about how I could have made that any better.	P8, 290-295 P9, 311-314 P21, 845-849		
‘So I spoke to the GP again because it feels very tight, like it can almost feel kind of.. very lumpy, like when I was walking it was giving me pain or moving around too much, but pain all the way from hip side down to like, the top of my pubic bone, it was quite painful,’ ‘It is tender, I mean it is seven months down the line, but if you kind of catch it funny it’s.. you know it’s still not healed properly, or something’s not quite right, and it’s almost like you know that scar tissue doesn’t go away, it’s not.. it isn’t a case of time heals it, it’s always that horrible.. It’s that lumpy, hard tissue underneath the scar.’ ‘it’s still painful, its still painful, like I said I still can’t go to the gym, at the 6 week mark, but I couldn’t do it, it was um, it’s like a sharp pain really, it’s just constant, and even now if I just touch.. if I touch where they like opened up the muscles, it’s tender, I can feel that there’s still that bruise inside, I don’t know, it’s weird, um..	P6, 220-224 P8, 313-318 P7, 276-282	Healing as loss of pain/ scar sensations/ return to normal bodily function	

yeah and if I do any sort of movements too much or too sudden like a jump or something there's pain there.'	P19, 769-775		
'It's just uncomfortable, like.. it feels like pins and needles but not, and if you like sort of touch that area it's just a weird sensation, um, so like if you're creaming your body and like whatever, it's just like such a weird sensation and I feel quite cringe about it, erm, I don't think about it on a daily basis, but you know, sometimes it's like I'm creaming my skin or something and I'll be like- ugh'	P8, 278-283		
'and it's very bizarre because all the area around the scar was numb (I;mm hmm), you know, really, really numb, but I could not even have like, soft leggings, or pyjamas, over the.. the stitching, because it was so painful (I: mm hmm, ok), so it was really bizarre, you couldn't.. the area.. the skin was all numb, but the scar itself was so highly sensitive.'	P21, 842-854		
it's not pretty, um.. ehh, I don't, yeah.. I don't feel.. it doesn't bother me, like I wouldn't be embarrassed, we've been on holiday, and I wasn't embarrassed by it, you know, if my bikini went a little bit lower or anything, but it didn't… It didn't.. it doesn't bother me, but it.. I feel like my body.. my body around there, like I didn't.. I still had lots of sensation for a long time after for many months.. like I'll feel it a lot, you know, like I'll run my fingers over it and stuff and er.. yeah.. it's not pretty (I:mm), definitely.	P5, 172-177		
but even now where my.. you know, if I'm stood up, and I press down where my C-section scar is, I have a section about that big, where it's all um, scar tissue (I:mm hmm), it hasn't gone back, nothings soft about it, it's like a brick underneath my skin, and I do, you know, if I cough or if I laugh or anything like that, it hurts	P17, 677-680		
so it's just more so when I'm turning over in bed, searing pain along the tummy area there, um, like a sharp shooting pain happens around the C-section area, um, just generally just, not very nice feelings.	P15, 637-645		

, it was a bit later at 8 weeks, they combined it with her first vaccinations to minimise appointments, and it still felt like my entire insides had just been like (makes squishing sounds and movement), kind of shoved back in, and it was all kind of, felt like everything was still, like that feeling of when everything is kind of shrinking back, and everything is kind of moving back into place, kind of displaced feeling for such a long time in my abdomen, it was really very surreal, um, and it was very uncomfortable, for a long time on top of the um I had other operations in the past so I know, you know, you never fully heal, there's always the.. residual times of pain, or twinges, um, so I don't expect that that kind of… grief and you know, not only did the birth not go… it is a irreversible thing, once you have a caesarean, your body is changed, forever, um, and that's, in not kind of in the natural way of yes you've given birth, but your body just kinds of goes back and is ready to go again if you want to, you know,	P18, 771-773 P18, 784-789		
I think it's gonna take.. Probably up to a year for it to completely heal, um.. For me to be able to do like the normal thing I did before, I think things just felt not so huge, and I know I keep saying it, but to just get out the flat, or to.. try and do a little bit of housework (I:mm hm), you know, just the basic stuff, I think if I went back running again (I:mm hmm), I think I would feel like that was.. in my body being my own again….. yeah I think if I could get back running and high impact exercise, I would feel a bit more like myself. it's the things you took for granted.. I.. yeah.. I now feel like a bigger thing. she's a very experienced beautician you know, so I.. but she said.. when she said to me at that time, I think it was during March or April, yeah it doesn't.. I'm not going to wax, not hot wax on that, I remember thinking- oh, Christ (laughs), you know,	P7, 293-295 P14, 538-541 P18, 715-717 P18, 728-729 P21, 883-891	Healing as resumption of normal roles/ activity	

she said it just.. it just still looks quiet erm, what is the word she used, puckered? (I:uh huh), and raised (I:mm), she was like it's still healing, I'm just not going to upset it there, and I was like-ok, no problem (I:mm, ok), but I remember coming away thinking- God (sighs). and I remember when I did go back to pilates, it was late March, April time, and just being horrified at how pathetic I was (laughs), like I was.. I was like a.. yeah.. no.. that was a shock (I:mm), that really.. and that was an eye opener on how much it really physically affected me. I stared exercising 5 months, yeah, 5, 6 months more like, and er, that's when I felt more like me. I: mm hmm, and would you consider yourself now fully recovered? H: no, not until I have that operation, because I can't.. I can't exercise as I see.. as I want to um, when I, you know, when I cough or I do certain movements it hurts. , I was completely isolated, um.. and in a lot of pain as well, and I couldn't obviously drive for quite a while, we left that a bit longer as well because I was so.. in quite a lot of pain, the doctor said it's when you feel you can comfortably do an emergency break should you need to	P22, 907-911 P15, 588-590 P15, 599-602 P16, 676-680		
'Well the doctors were just like 'well it's just one of those things, you're healing' and I was thinking- well it shouldn't really be one of those things, it would be nice to find out, to know exactly what the problem might be.' 'but I mean I did have the Doctor, you know I said about them not being able to speak to them, asking about the pain I'm still having and ending up having to pay for physio, I mean the exact words she used to me was 'Well, what did you expect?' 'Well look it seems to me like… There's.. You're very unlucky if you get a wound that's not healing, so it's like 'Oh you're fine, the stitches will dissolve in couple of	P7, 225-228 P9, 327-331 P 14, 556-560	HCP undermining wound impact	

days, and then keep the area dry'. So it's almost like it's not expected to have those problems'			
'.. I spoke to the Doctor and I said you know said it's hurting a lot, and they said it's normal, and just take ibuprofen and paracetamol,'	P6, 250-252		
' Because I would like suffer from pain on that side going forward, nothing like excruciating, nothing like 'Oh, I can't move', just this constant pain and discomfort, erm, so that's why they scanned me, and then they said I have internal bruising but they can't do anything about that, it's just usually like… like possibly it just needs to heal on it's own'	P4, 93-99		
but each time it.. it was a bit of um, you know, they just checked it, and they didn't really do anything else, and it was black and goozy and I said-oh, I think I feel I need to have some antibiotics with things going on there, and they're like- ummm, umm (makes pondering face), I thought- just give me the antibiotics, and you know, that you know, takes out the risk there, so um, yeah all in all it took a long time to heal from that,	P5, 166-172		
, I don't know why they didn't think it was more of an issue, but I suppose they just think of it as- well, it will just bleed out until it needs to bleed out, you know, it just will bleed until it stops, that's what one of the midwifes said, she said- it will just bleed until it stops.	P12, 487-491		
um, I went to the GP to have it checked out and she just said- oh, that's just how it is. (I: mm hmm), um, and you know, I can refer you to physio if you want. And I said- yes please. That was a 4 month wait, and then I told you they just did it over a voice call, um, so you very much had to take it into your own hands, and self- fund it.	P15, 602-607		

'it's still very, it's always going to be that tight scar with a lumpy bit, the over-hangy bit, and lumpy, erm, yeah just one of those things [laughs a little].'	P7, 232-234	Dealing with an altered body/ negative body image	
': Erm.. there's always that, well..I it sounds a bit vain saying these things, but it is..it's your appearance and your confidence as well, like what you look like in your body, 'cos having had the previous scar, it doesn't matter how thin and how much exercise I did, that area never looked and got down to like how you wanted it to.'	P8, 298-302		
'I've put on a lot of weight, and.. With this caesarean like, it causes more of hang of the belly you know, over it, um.. And I'm quite conscious of that, and because I'm a lot bigger, it's difficult, because I feel quite insecure, and I can't really go to gym, or do what I used to do you know, or do what I used to do to get rid of it?	P9, 357-362		
'I was horrified by the scar, erm, and there again you know… I'm used to wounds and things, and I remember just looking at my body, and I just er.. I remember looking at it going- oh my God! It was just.. it was so ugly, and really poochy? You know, all the skin gathered so it was almost like a.. another belly, a second belly, and it just.. again, it didn't feel like my own body'	P8, 272-278		
whereas online, lifting up my top, and I think also because I had to see my body? (I:mm), through the camera, I was like- uugh, God!	P19, 755-756		
I hadn't really out n weight during the pregnancy you know, as I kept myself very trim, but then.. I definitely put on weight postnataly (I: mm, which..), I was just eating junk, and I was breastfeeding so I was just eating.. Just snaking on anything I could get my hands on (I:mm), you know and um.. yeah, eating junk, so I didn't feel great about myself anyway.	P22, 895-901		
I bought a balm, and I was really massaging, trying to break up, the kind of, tissues, when I spoke to the GP about it she said- that's not going to make much difference, the only thing that would work is if you have it cut away	P15, 613-617		

so I kind of have to live with this for as long as I can before I do it. I've started going to the gym again as of last week, and I feel like I need to learn what my boundaries are with the body that I've got right now?	P16, 639-640 P16, 647-649		
, I don't like to touch it, I don't like anybody seeing it, it's just.. I think because it's so hard, it's just.. (makes a 'bleurgh' type noise), the thought of it just turns my stomach a little bit (I:mm hmm), I'm not like that with any other scars, it's just um, you know.. even now it's a bit sore, you know when I press down on it it's a bit sore, so I just rather not go near it.	P19, 762-767		
well it's a very messy scar, so it's not even you know, neat, it's all over the place and it's you know, some has keloid-ed, some hasn't (I: mm hmm), um, you've got the really hard area underneath it, that it's just, you can't even press down, it's like pressing.. a hard piece of meat, you know it's like muscle, it's like muscle behind it ,even though it's not, so it's not even like you could press down and it feels smooth, it's solid, so it just doesn't even feel like it's part of my body, it's weird.	P19, 770-777		
never in a million years would I for example with my fiancé, would ever want him touching that area, like the thought of that just actually turns my stomach just (makes a disgusted noise), just no..nah, no, no (laughs).	P20, 796-799		
.. I still get..I still get quite you know, I can still get quite um (sighs), pain, scar pain, and kind of internal muscular pain as well, I feel , yeah, it's been a really tricky, yeah it was a really tricky, long recovery.	P14, 574-577		
starting to feel a little bit more comfortable now, but it's taken a very long time, um, I just got to watch myself when I do any lifting, or even lifting (baby), or sometimes I get shooting, numbing pain for no reason, you know just through the scar	P16, 685-689		

, I've got various other scars from operations, when I broke my wrist and stuff like that, when I was a child, um.. that kind of feeling, it's that severed feeling, that feeling like a kind of irreversible feeling, like you can't.. it's not me anymore, I'm not me as I was?	P20, 859-863		
'.. I think I found that all the way through any of my pregnancies and after the births, it's always very.. It's like you're not listened to properly, it's like 'well the text book says x, y and z should happen' but you're saying something and its.. I find it quite frustrating that your feelings and your experiences and what's happening to you aren't listened to properly.' 'and then I sat there in the waiting room, and I said to one of the people that I can't sit here, like I'm in agony, please help, um, and then they told me to walk to like a separate room, and I was like I can't move, I can't walk, you know, like I'm literally, any movement I make, I'm in agony' but they were going to um, like discharge me without any pain relief, and I said to them if I go back to the state I was in before.. But I'm scared, please help me, you can't just discharge me like this, um, and my friend came to like pick me up, so she spoke to them, she was like- look at her, like she can barely move, she's in a state. And I started to cry because I felt like you're not helping me, like, I'm not dramatizing it, I'm not making it up, it was so genuine, like please help, like and I started to cry, , I think possibly they didn't take me seriously, I don't know, maybe the way I was communicating it, I have no idea, , I said to the midwife like I can't have it right now, so basically that was when the infection had started but I hadn't noticed, because no one had come and checked the wound at this point, they were just doing the rounds for the injections, and I said to the midwife I cannot move, um, I can't have this injection right now, like I'm in too much agony, I can't have it, I said can you come back in a little while, like because I was due like um, pain relief, so I said like can I have the pain relief, let that	P7, 237-243 P8, 280-285 P8, 298-305 P9, 308-310 P15, 606-615	Not being listened to/ taken seriously by HCP	

set in and come back and do it, and then I might be able to move again, and she wrote down that I refused it' And it just made me feel like you're treating me like I'm over exaggerating or something, like, you know, like being like - oh, it can't be that bad, when I was like it really is that bad, I can't move in the position you want me to move to take, have this injection. 'my GP was.. was crap (both laugh), brutal, I had to say- er, are you going to look at my wound because the midwives want you too (laughs), and he was like- no, and I was like-please? (both laugh), because there was a section that wasn't closing (I: uh huh), and he looked and he was like- yeah all looks fine' he made me feel like I was a bit of a nuisance (I: mm hmm), like silly woman, you know, what are you talking about (laughs), it's fine, you know, it's fine, oh yeah, it looks fine, but he barely glanced at it (I:mm yeah), and I was just like- oh? (laughs) so I went to hospital, and they looked at it, and they just said- oh you know, it's just um, it's just taking a bit of time to heal, it will be fine, um, just go home, so I said- ok, and then, this blood.. pushing out, what do.. what I do with it? Do I.. Do I have to dress it? Do I have to put a plaster or pad on it? They're like- you know what, just put a sanitary pad on it, it will be fine, and I was like- oh..kay, and I said.. any, you know, the pain relief? And she said- oh, we don't do that, and I was like- but I was told by the anaesthetist. No, no, you can sort your own paracetamol, I was like, but I've been on dietary codeine, and she was like- no, no, we don't do that, and I was like- oh kay.. so I asked about 3 or 4 times, and this was with the student midwife there, I was like- ok, paracetamol and ibuprofen it is (laughs),	P16, 646-650 P19, 738-742 P19, 767-770 P5, 152-158 P12, 488-494		
'it's quite a lot of information to take in, and then you have a consultant or a doctor saying certain things at you, and I you're sometimes.. I think sometimes you're not in the best place to maybe say exactly what you want to, or remember things,'	P7, p 256-258	HCP communication as one sided	

', I still think it's extremely poor information given to you before you have the C-section, and you know they can read out all these things to you, but when you're in the middle of contractions and all of these things, that's not the right time to get that information, I know you have to sign your life away basically, but I think there's information that can be given before'	P13, 507-513		
'and I said to her- look, he's not latching properly, I need help, there's something wrong. And she looked and she watched, and she said- Oh, he just needs time to understand how to latch, and I was like- what? That doesn't make any sense. Then five days later I had to go and see the midwife for her to take the boards of the wounds, and she was an older one, and I said to her- Look what's going on, bla, bla. She watched, and she looked in his mouth and she said he was tongue tie, yeah, and the quicker you see tongue the better yeah, because it affects your breast milk supply and it affects your breast feeding in general right, so the quicker you see it the better, and I was just um, shocked at the care that the midwives are coming out and they don't know what they're talking about, and that really affected the breastfeeding'	P11, 439-452	HCP advice as contradictory	
'and this is when they've done their crossover with shifts, um and I said I'm in absolute agony, like and I was crying at this point, um, and she said-alright, let me take a look, and that's when she saw that it was infected and there was like puss and blood coming out, so she had to um, go and sort all of that out and stuff like that, dress me, stitch me, you know, sort all of them things out, um, but she said like obviously with you explaining you were in so much agony, she probably should have looked at the wound (I; yeah), like I have, um, because she was like it probably was infected from then and that's why you're in so much pain, um, but she just wrote on the notes that you refused it, which I actually didn't'	P16, 620-630 P19, 773-781		

'and the midwives had told me to make sure I got to the GP to look at it (I: yeah, yeah), that was their advice, and he said- oh these midwives, if they have an issue they should refer you, and I was like- oh for God's sake, you know I work in the health service, I know how this works.. it.. it takes you nothing just to have a look at my wound? (I:mm), and he was like, and he said to me- you tell them in future if they have an issue just make a referral. I was like- oh for Christ's sake (laughs), so that made me feel a bit like.. well where do I go now?' we went into another night where at 2 o'clock in the morning I literally broke, I was just… sobbing down the phone to a midwife in the day assessment unit, and she was like, oh my goodness, I've never in my life, sent someone home after a Caesarean without pain relief	P13, 533-537		
'So it does look different in clothes than you want, and it's choosing the different clothes, and like I can't have underwear or trousers at the minute that sit or would sit on that line as it would dig in and it's sore and ermm.. So I think there's that impact that you have with what you look like and what you can wear and how comfortable you are' 'I couldn't go back to gym for like.. I know they said wait until 6 weeks anyway, but even at that point I couldn't because when I tried it was too much. It's only now, I'm able to do some things, but it's still.. it hurts too much so I just try to do swimming,' 'Well it's really upsetting, I mean I wanna, I actually want to get into martial arts, Jiu Jitsu, and I can't because of the wound,' but now it can' come any closer together because of the scar mass that I've got under the skin? Um, so if I want to bring it back together, I'd have to have that removed, and as a result I can't do things, like running hurts, um, any form of sit ups or anything like that are an absolute no, um I can do cycling, er, but really, I've just got to take it easy.	P8, 30-308 P6, 236-240 P8, 304-305 P15, 593-598	Regaining normality (clothing, activity)	

, ultimately if I want to kind of, get my life back, which is you know, exercise is the way that, that's my only hobby. it's frustrating, um, but at the same time, you know, it is what is, what can I do about it? The only thing that I got control over is that, so I've just got to concentrate on that, and see where I get to, and then at least I know where I stand, and I don't have to be stuck completely not doing any exercise, there is a halfway house that I'll be able to achieve, I definitely would not wear a bikini, um I wouldn't feel attractive in nice lingerie, just um, I just um, which kind of makes the whole idea of all of that, I'm just like (makes a disgusted noise). I still can't tolerate wearing anything waist.. you know,I live in leggings and dungarees, anything with a waist, any zip, the thought of .. I basically still wear a lot of my maternity pyjamas and stuff like that because I just..just can't.. any restriction around my.. around where my incision was, it's been really , I got to be careful with mobility, with lifting, even now, um, I mean I have a tendency towards things like dungarees and comfy clothes anyway, but um.. yeah I really.. I don't know if I can go back to wearing things like zips and stuff, you know, maybe in time I do, but it just feels very um.. yeah, vulnerable and sensitive and so.. yeah..	P16, 634-636 P16, 659-664 P19, 784-787 P16, 680-685 P19, 816-821		
'then there's the impact of the pain that you get from it and most of it is pain more so when you've had a really busy day, so, or doing exercise, then you start to go 'ooh, I don't want to do that' because then it will be uncomfortable, but then you don't want to put off exercising because you know it's good for you, so I think there's that impact as well'	P8, 308-313	Impact on daily routine/ self identity/ Mum identity	

'well at the start it was very difficult, because.. ermm.. with the wound not healing, and then you've got a baby that you're trying to hold and feed and look after, with the lack of sleep which doesn't help your body with healing anyway'	P10, 259-362		
'I wanted to go out for walks but because this wasn't healing and I was having so much pain from it, I don't think I was as mobile, I couldn't go out for walks like I did with my other two children, erm.. yeah I think it had quite a big impact and it does for quite a while after a C-Section.	P10, 381-386		
'and your hormones all over the place especially, and then you're tired.. I think it makes all of that a lot harder, the usual once you've given birth kind of hormone fluctuations, and the tiredness and lack of sleep, and then you throw that in as well, the wound and then it not healing, and the pain, it just makes you so much more.. I don't know, I suppose a lot more miserable, a lot less able to cope with certain things, erm…It's harder to feel a bit more.. I don't know how to explain it…'	P11, 400-408		
'It was agony, it was so much worse than the first, I mean for 2 and a half weeks I was waking up in the night crying, you know, just begging my partner to get the um the painkillers, because it was that bad, like I've never experienced anything like it, and you know, I was trying to breastfeed, and it was just.. It was just crazy, it was just really, really hard and really, really painful, I couldn't walk without feeling like I was going to faint, um, it took maybe 3 weeks before I could actually walk around the block, without feeling like I was going to faint, I felt very weak for a long time.'	P5, 199-208		
I mean even now, I still get pain and it's nearly 4 months on. So if I do too much or walk too much, there's pain, um.. I can't do sit-ups, I can't do planks,	P6 233-235		
, I went to a supermarket about 4 days later and I was in tears, I was crying, I was like- I can't do this, I need to go back, I literally cannot do this. I couldn't hold my baby for long periods of time, um, and my breastmilk as well was affected, it loses everything, honestly, I know it sounds.. But it really was, it was just horrible.	P6, 241-246		

'obviously like I said my partner was doing everything because I couldn't, bending down was, was ughh.. I couldn't do anything, just getting out of bed was hard enough or waking up in the night to feed my baby was hard enough'	P8, 322-325		
the only thing now to do with day-to-day duties is still like if I'm trying to get out of bed with my baby, like lift him up, that's a problem still, I'm conscious of the wound because I can feel it.	P9, 340-343		
', I would say about 6 weeks, 5- 6 weeks before I could like walk outside and like push the buggy and go for a walk and stuff'	P4, 85-87		
'it made you feel a bit like a failure in one sort of sense, due to the fact that I really struggled erm, to like get up and change him, to feed him, I needed a lot of assistance, erm, in doing the basic things that a Mum would do for their baby, and this was quite, this was for quite some time as well that I needed a lot of assistance for, so it wasn't like you know, for the first 24 hours that I was in pain, it was.. like it was ongoing'	P5, 154-161		
'so I just felt a bit like, erm, unable to do the job that I'm supposed to be doing.'	P5, 167-168		
doing things like not being able to wash myself properly, erm, because I struggle to get in and out of the bath, like to lift myself, and like you know, just basic housework, that really affected me also. I: yeah, in what way? S: It didn't link to the baby, it made me feel as a woman, I can't.. I can't operate properly if that makes sense? So it really got me down at that point.	P7, 228-235		
'it was just really hard because I wanted to do certain things with my children, and I couldn't do them, and I wanted to do certain things in the house, like you know, cook them dinner, or give them a bath, or you know, things like that, and I couldn't do that for some time, which really got me down.'	P9, 320-325		

'although after the five six weeks I was able to walk around and stuff, I still have this pain like every now and then, like it will be like a sharp, shooting pain,'	P11, 431-433		
.. I've always been quite fit and strong, and I had done Pilates the whole way through, I had done Pilates the weekend, just before I'd given birth to (baby), um, and I think.. I think the caesarean made me feel, um, for the first time.. I, I played rugby for years and I hurt my pelvis very badly years ago, and it made me feel like that, it made me feel almost kind of quite scared, to.. to.. to move normally.	P7, 216-222		
(husband's) father came over when (baby) was 3 days old, and erm, I went out for my first walk, and I had to walk like a.. a very elderly patient of mine, like at a snail's pace, and I remember just thinking this doesn't feel like my old body	P7, 225-228		
, and then he was, we had a, you know like a co-sleeping crib, where they're not co-sleeping but they're, you know like lying beside you (I: next to you) kind of thing, exactly, and, and getting him out of the crib in the night, you know you're meant to be able to scoot them across (I:mm hmm), that was absolute agony, I couldn't do it	P10, 348-353		
and the weight of the buggy, when I first started trying to push it, after the section, I just couldn't do it (I:mm mm), you know, and that again made me feel quite um, again dependent (I: mm), and it did, I felt like, you know it's so difficult to get out the door with the baby anyway (I: yep), and then, it just added another thing and I remember it made me feel really frustrated, and a bit.. a bit pathetic at times	P10, 375-381		
.. I think I just, I know I keep saying it but I think I just found every time I left the flat just massively, like a huge task?	P16, 620- 622		
I think I just got to the point where I'd worried so much that it was, it would cause more bleeding, but by that point because it was still bleeding I just thought-well, its… I might as well just get out the house, but it was really painful, I was walking like a little old lady, you know	P13, 5017-512 P13, 526-528		

.. I mean our bathroom isn't far from our bedroom, but it took about half and hour, forty minutes for me to shuffle from my bed, to the loo	P13, 559-562		
you know, it was heart-breaking, I couldn't even.. you know, we had a Moses basket on a stand and I couldn't even pick her up from that, I couldn't put her down, I couldn't.. I didn't change her nappy for..ages, because I couldn't get down.	P14, 569-572		
, I couldn't feed, sort of being taught about laid back feeding, and I couldn't, I had to have her this way, and I couldn't have her below the stomach, er bellow the belly button, it was just.. probably about 4 months or more, before I could tolerate even slightly, any pressure,	P14, 574-581		
, and for months I basically didn't get out the house because I was unable.... and even if I did go for a walk, it was literally not very far, partly because of the feeding frequency, um, and just I was literally shuffling, I couldn't walk properly for months, um… um.. yeah, so it's been, yeah, it's not easy.			
it really impeded me being able to do what I would otherwise have been able to do, um, you know with the physical pain, and being in and out of pain for such a long time, um.. even just going for a walk, you know, you'd think taking your baby for a walk would be a normal thing to do, but that was just really, umm.. really hard to do, um, and things like I couldn't use the carrier for a long time, because I didn't have the stamina, to be able to walk any distance with her so that kind of,	P19, 824-831		
because of the feeding and the ability to feed her, um, and the position which I could feed her, and needing to be in a place where I had, can comfortably feed her at home, in multiple ways basically with my caesarean recovery and with feeding pain, um, so.. yeah, it was very, very limiting, it felt very isolating, um, and very frustrating,	P20, 844-848		
and it was really hard not to have judgement for yourself, when you want to do your best for this little person that you've chosen to bring into the world, and.. and	P20, 849-854		

it just.. I know my natural capacity and it's just been.. so depleted, and still is.. very depleted, um, it's been a long term haul, you know, er effect.			
That was my point.. how long am I supposed to take lots of Nurofen and things for it, you know, is it something that's ok to take for years to come or like, why can't you look at fixes? but then there's this fear that then my pelvic pain will kick off (I: yep), and I'm restarting.. you know, restarting my masters at the end of the month, and I'm very aware of my pelvic pain and like the long episodes of studying, you know being at the desk, you know all those things, I think you're just, you're more conscious. I'm not very um, I'm not a very doom and gloom person, I'm quite a positive person, it was just I think whilst it was still bleeding you think- is it always going to bleed? Is it never going to get better? Is it going to get worse? I was just really overwhelmed all the time, um, and I had you know, it was just one thing after another, after another	P9, 226-339 P18, 717-722 P7, 257-260 P19, 838-839	Never-ending healing/ dealing with an unpredictable body	
: Oh that was horr..it was so scary, um, I just didn't know what was happening… to me, erm I literally, I just woke up in the middle of the night, so obviously I was still sort of half asleep, not asleep, and I just got his horrible pain and I just went all stiff, like any little movement I made, was agony and it was like, sort of like my shoulder, my back, and then my scar was obviously hurting, 'cos it hadn't healed yet, so I went stiff and I was in a panic,' In terms of the pain it was scary, because I didn't know what was happening to me, but also it was horrible because, I had to leave my newborn baby with my Mum, because obviously I had to go by myself, I couldn't obviously take the children, because I couldn't really help them at the time, I couldn't even help myself. erm, but it was horrible, just to say bye to my newborn baby, like he's like a week and a bit old, you know, um, I wouldn't have left him of my own accord, and that like, at that early on in his life, so that was really horrible,'	P7, 245-251 P7, 253-262	Loss of control over postnatal body	

I remember, I think I sort of like, I didn't go unconscious, but I sort of like, I think I went a bit like delirious, maybe through like the stress of it,	P8, 274-276		
'It's so funny, I think about it now, I think I was just on autopilot? (I:mm, yep), I just couldn't quite believe this has happened, and also your numb, your catheterised, erm, you can't move, at all, or you know, kind of from the midriff up, so yeah I think I felt really quite, I guess feeling on autopilot.'	P5, 166-170		
), and I've never experienced pain like it, it was like a hot poker, every single time, the whole way through m.. my stomach, it was excruciating, and it wouldn't just go away, it would linger for maybe 15, 20 seconds, (I:mm) and that same intensity, and that lasted.. God that lasted for about a month.	P6, 208-213		
even though the rational part of my brain was like for God's sake, you just had massive abdominal surgery, you know.. it doesn't.. you know yourself, you just had a baby you're all over the place, it doesn't erm, the irrational part of your brain just takes over.	P10, 382-385		
it did force me, so that's why maybe I was just able to just mellow into it a little bit more, because I.. had to.. I had to, take it fairly slow (I:mm), I simply could not do even a third of what I would normally do.	P15, 590-593		
well not angry really, but you know like, I was like- they could have checked it (I: mm hmm), you know, like I kept saying that, but then I'm like, you know what? It is what it is.	P4, 91-93		
'again, it's C-Section, so um, it can take up to God knows how long for it to heal properly, so I didn't have like um, I didn't have like a time limit to say oh, like 2 weeks this needs to be healed, so I was just like… going with it really.'	P9, 284-288		
	P5, 140-151		

the midwife came round on day 5 to come have a look at my wound, and take the dressing off essentially, so when she lifted the dressing off, well she pulled down you know, my knickers, and she said-oh, er, oh, this doesn't look right (I:mm), I said- what do you mean? She said- it's.. It's sodden in blood (I: mm), so I said-alright, and I hadn't done anything that made me think- oh, it's because I bent down or I've done a sudden movement, I hadn't, I actually bought a mobility chair this time around to make sure that I wasn't straining myself, I was being really careful, and when I went and looked in the mirror, I lifted up my, you know, pulled down my trousers and lifted up my top and I thought- God, you know, it was soaked in blood, You do catastrophize thinking about.. you know, when I was taken by my Dad in the middle of the night and by the ambulance, I thought am I not going to be able to get back to my children? Am I never going to see my children again? Am I going to bleed out here? And am I going to die? You know, you think all these things because obviously hormones are all over the place and you're panicking anyway, you're sleep deprived, and you, and I remember just cry- and I don't ever cry, for anything, I'm not a crier, but I was crying on those two occasions going to hospital because I just thought, maybe I'm not, maybe I'm not going to see my children again, how are they going to cope? You know you just.. really panicking about things like that, but then I woke up having convulsions, because I think my body was just in complete shock, um, so that was interesting	P7, 260-271 P13, 551-552		
and it was also like scary being by myself as well because obviously at the time my Mum was supporting me, but she needs to watch the children (I: yeah, yeah), so that was a really like lonely, scary time, because I just thought I don't know what's happening to me. but yeah very isolating, very worrying because I've never heard of anybody else whose C-section scars' constantly bleeding for that long, 2 week, yeah, maybe 3 weeks, but still bleeding at 5, 6 weeks, it only really stopped at about 7 weeks so it was just quite erm, quite eerie,	P7, 262-266 P6, 204-208	Feeling isolated/ Like an anomaly	

there is not an awful lot about that information at all, um, so you do feel a bit of a spare part, really, and you're just hoping for the best all the time You always think that won't happen to me, don't you (laughs), you know, it happens to somebody but it won't happen to me, I don't feel like I'm a representative of the majority, um, I do think, you know, you should always be aware of what's happening, what could happen, but at the same time, you know, anything could happen with a normal vaginal birth, couldn't it?	P14, 546-548 P17, 708-710 P20, 817-821		
'Yeah [laughs] and I was like, well I don't know why you have to, because you're a woman and you've given birth, have to just that's it, the end, like you can't be frustrated, annoyed, or in pain really [laughs], why should you.' 'The Doctors view is well you're a woman, you've given birth, tough really that's what you're stuck with now,'	P9, 333-336 P9, 343-345	Safe delivery trade off	
''cos like my physio said, 'cos that's the area around your core as well, you end up getting more pain and problems in other parts of your body, 'cos you start holding yourself different, you avoid doing exercises, your core hasn't got the strength it has,' and then I would be scared that there's more damage inside you know, because I've been told there's bruising and things like that and I don't really know how that affects you, having another child. Um, so it would make me really anxious if I'm honest. and I can feel that, so if I have any break in exercise now, my hip.. my pelvic pain really flares up (I:mm, ok, so..), and that feel like almost like a lifelong consequence. it's just in the tummy area, which then impacts my back, because obviously you need your core to stay in the right position, and you know, stay upright, and then if that's all gone, then your back starts hurting because you're stooping down,	P9, 339-343 P19, 760-764 P17, 675-677 P17, 674-677	Long term impact of wounded body	

.. because it's something irreversible, you know, I feel severed, I feel like.. and the thought of you know, having any more children if we were too, you know, the fear of being pregnant again and just like medically I wouldn't necessarily split open anytime, the fear of that is during labour, there is that fear, you just feel more vulnerable, and worried that it might affect fertility, and other things, which wasn't easy in the first place, and.. the grief of the fact that I can never probably try for the type of birth that I'd ever.. I know you can do VBACs, but there's always the you know, high risk, you've got to be in the hospital, or, you know, they probably will be trying to convince you to have a caesarean,	P18, 774-784		
'I do find that erm.. It is a major operation really, and I think because you've had your baby straight out of hospital, and you go back to being at home, and kind of having to just get on with things, and maybe if you've that surgery, or a similar surgery but for a different reason, or in that area, or.. I think you would be given a lot more instruction to stay.. you know like immobilise yourself a bit more, don't do as much, erm.. get a lot more help, but I think it's those.. You come out and you have to be 'the Mum' to the new baby and if you've got other children, those children, and your husband goes back to work after a couple of weeks,' 'I think that and I do think it impacts on your bond that you do have or want to have, because it's the holding them as much, like it's not easy, you can't hold them for as long, and things like breast feeding are a lot more difficult to do and establish, and there's those feelings around that, I think it does have quite a big impact on how you feel as a new Mum' 'It really did, and I remember the anxiety the night before, it was just dreadful, and I'm not a.. I'm not an anxious person by nature (I:mm), but I really, I really felt highly anxious and.. and.. bereft that he was going back to work.' so my flat was a disgrace (I:laughs), and I looked at it, but I kind of was just a bit like- eh, we're all right, we're clean, and we're fed, (I:mm), you know, and his	P10, 362-372 P8, 262-265 P14, 551-555	Negotiating maternal/ self identity	

clothes are being washed, he's being.. the basics are being done, I'll just focus on that, and that's what I did. I wouldn't dare lift up my tod- you know, my 11 month old, wouldn't let my other one, you know my 3- 4 year old go near me, because I just thought if he jumps up on me and it all goes wrong, so at best I could erm, erm, I could hold my newborn, but even that, I couldn't get her in the right position that wasn't putting an impact on there which then made it bleed more, you're kind of stuck really then because you're trying to not make it worse, but then when you've got kids obviously you can't ignore them (laughs), you've got to pick them out of the car and like my youngest doesn't walk yet, so there's not really any other option.	P7, 229-234 P17, 685-688		
'I think it's.. you are.. You're frustrated and sad because you want to.. you don't want to be not doing what you.. when you've just had a baby, and you want to be going on a nice walk with them in their new pram, and enjoying things and going out places, but you know, you can't do those' 'I felt like everything I was doing wasn't good enough, you know, because everything just wasn't right. I had.. I had something in my mind of what I wanted, and that was to have a vaginal birth, and to be able to walk around, look after my older child, you know, I know for some vaginal births it's not like that, but for the vast majority of what I researched is that normally a vaginal birth allows you to have quite a normal life quickly afterwards, you know?' 'So with my daughters, first pregnancy, it was complicated throughout the whole pregnancy, and the birth and then like after the birth, whereas with erm the most recent child, all the pregnancy was all straightforward, so I did.. I had more hope I suppose this time round to be able to do things for him without having to struggle'	P11, 392-396 P10, 407-414 P6, 179-184	Mismatch in postnatal expectations/ feeling unprepared	

'and I just felt like I didn't get to experience that, like with um, neither of them I didn't get to give them their first bottle, you know things like that.'	P6, 190-192		
'um I suppose with this pregnancy, with this latest pregnancy, I had a lot of hope that it would be more smooth sailing'	P12, 447-449		
you don't really go in thinking I might have.. I might need support for a longer period of time, or extra childcare if you've got children before, you know, which can all be extra pressures that you think about, but you don't think that you'll need them for such a long period of time.	P12, 460-465		
'I still had a lot of hope with the second one that it would be really smooth sailing and less traumatic, um.. because the under signs as in the planned c-section, um, all the scans and stuff being fine, I just felt like this was a way more positive experience, so it led me to think there was um, like a more positive birth coming, which didn't,'	P13, 525-530 P7, 229-233		
because I had a fantastic first trimester, I felt really strong, fit, I had lots of energy, I felt great, and then suddenly at the drop of a hat I was crawling (laughs) around up the streets really at just a snail's pace, so that felt…Er, yeah that did make me feel vulnerable,	P8, 288-292		
I also didn't realise that I would bleed, because obviously I hadn't prepared for a section, I didn't realise you would still bleed after a section, so you bleed as much as if you had a vaginal delivery, so I had to wear these pads but I couldn't tolerate the knickers over the scar?	P10, 358-362		
I found that really difficult, and I was like, it isn't meant to be like this, it's meant to be just pull the baby across, breastfeed him and then just pop him back in the crib (laughs), and I remember thinking.. it's nearly, it's nearly made the crib pointless.	P10, 364-366		

and I remember thinking how come no body every said that about a section? You know, you didn't see anything like that, because it was so painful for so long.	P13, 500-504		
but I took nothing from the antenatal about the caesarean section stuff, and I wish I had (I: yep, yep), because we were completely unprepared, like even just.. Even just injecting yourself with the anti-clotting agent every night (I: mm, ok), you know, that was … horrible (laughs)	P8, 267-273		
so um, I was ok with it to be honest, I mean, so I knew after the Caesarean I would have to be in bed for like 3 or 6 weeks, and again because I've been this way before so like.. so it wasn't anything new to me? (I:ok), um, yeah, I mean with the oozing, that was kind of like new, but I soon adapted to it (I:ok), so I soon adapted to getting my husband to dab it, or.. or to rinse it off (I:mm mm), well, yeah..	P17, 699-702		
oh God I had no idea that that could happen, like yeah they talk you through- this can happen, da da, reel of a long list of things, um but yeah there was no.. There was no guidance. No guidelines given on with anything to do with that	P13, 540-545		
because we've said to all our family we wanted a couple of weeks juts to get used to you know, feeding, and getting to know little one, and then we'd have visitors, um, my parents we phoned them at like 4 o'clock saying can you come (laughing), and they were here by like 11 o'clock in the morning, um, and if they hadn't come we would have been absolutely screwed	P14, 566-569		
I didn't expect it to be like a walk in the park and there not to be any pain or whatever, but just to be.. I was just, basically immobile, for such a long time, and even at the.. you know, I was getting a lot of pain, I couldn't feed.	P14, 585-591		
there's been a lot of grief for things that had been lost, that cannot be reclaimed, like, things like our first day together, the disconnection of the birth, um, not feeling like I had an active part, um, the recovery, just not being able to.. just, you know, we chosen to be as responsive, kind of gentle parenting, responsive parenting, and			

to not be able to respond to her, as quickly as I wanted to, um, or even at times at all, like in the hospital. but I'm aware that I've been emotionally and physically unavailable for her way more than I had anticipated, than I wanted to be I did NCT and there was touched on with caesarean, but because it wasn't even on my cards that I wanted, you know, that was a yeah, if we possibly need it,'cos everything had been fine with the pregnancy at that point, um.. it was something we only looked at in a very limited way, um, nothing prepared me for being so completely.. (sighs) unavailable, and wiped out,	P15, 616-618 P20, 873-879		
I guess I thought that the Doctor would be the same, but I came to find out obviously, you know, I was just a bit shocked because I was so supported by the midwives , that the Doctors.. how they were, you know it was a bit of a shock, because they wasn't on the same page, you know what I mean? it makes me really sad that I can't look at the birthing pictures without feeling like I want to cry, and it makes me sad that I didn't get to experience what I.. What a woman should experience, you know, like I wanted to experience a vaginal birth ' I was really scared, because erm, before going in they tell you how long it's going to take, and there's like a clock on the wall. So I was like sort of mindful of the clock, I suppose because like I was obviously scared and anxious about the birth, so I was like- at least I know, in that time it would be done, erm and then the baby came out and I could hold him for a second and erm, they went to clean him up or whatever, and then I was like- this is taking like.. I kept looking at the clock, like- why are they still operating?' 'they had said it should take 15, 20 minutes, and nearly 45, 50 minutes I'm still there, um, my heart rate was dropping, my blood pressure I think was dropping, um, and because they couldn't get my son out, he was really stuck in my pelvis'	P13, 545-550 P17, 677-681 P4, 107-115 P5, 133-137	Mismatch in birth expectations	

I really having prepared for um, and upright natural birth, planning a home birth, um, with a birth pool, um, really wanted to, even if we ended up in hospital, to plan to have a vaginal birth unless it was necessary to have a Caesarean' it's a bit like, you know, you prepare for the Olympics for years, and then you're running a race, and someone just kind of stands you aside for the last bit and goes- it's ok, you know, we'll do this bit, and then.. and then.. I just happen to get the gold medal, so you have the gold medal, but I just feel like I didn't have an active part, in her birth, and it feels, still feels like I actually didn't give birth to her? It's like she was just… extracted (laughs), um, and that's been very hard to get arou.. To get my head around, emotionally, and psychologically	P4, 43-45 P7, 240-248		
'so the emotional side is that frustration, and I suppose a bit of anger, you've had another caesarean, especially one that hasn't healed properly, so that's caused more pain, ermm.. then like that disappointed feeling about how ermm…' 'So even like mentally where I was really hurt by it, and like still, it was quite traumatic, and even the pain was traumatic, and I feel they just don't see that, they don't want to hear about it, there's not enough support there, I think when a woman has to have major surgery and look after a newborn baby. There's just no support for her mentally or physically. ' 'I mean in the beginning I couldn't really look at the photos of the birth, the birth photos because I would be just so upset, it just really, really hurt me' I mean with the pain, you're going to feel pain anyway aren't you? It's major surgery, you're being cut open? So I don't know how much they can help with that, maybe give more advice on how to deal with and how to help the pain. I've heard of scar tissue massages, they don't tell you about that, you know, you have to look it up yourself, um, but yeah mentally I do think it can affect your.. your healing and how you feel about it.	P11, 394-400 P7, 260-266 P11, 420-422 P15, 632-639 P16, 644-651	Physical & emotional wounds (CS birth)	

I don't know if I'll think about the pain differently, but I'll think about the experience differently, okay, I'll think about the experience differently, and I guess you'd be more.. maybe you'd be more accepting of the pain, I can't explain it, I know it sounds weird, but you're sort of like, okay, it's one thing to deal with, rather than having to deal with the pain and mentally the thoughts that you have.. Because of the experience that you have with the whole situation			
'I think a lot of the time I was able to just get on with it (I: mm), because I was able to compartmentalise and go- oh, this is happening because of this, I understood the searing pain would be musculature, I was able to problem solve that stuff with myself, um, but I think it was the.. it was the real life consequences, the practicalities, the feeling vulnerable and dependent that.. that.. nothing had prepared me for that at all.'	P13, 508-515		
'um, a bit weak, a bit vulnerable (I:mm), and a bit I suppose, er… (blows out) tied to that event, in a way, you know, there's no kind of.. not.. not, and it wasn't traumatic, you know he was born safely and the care we received, it was lovely, you know, and everything else, but, it was erm..I think it's, yeah, it's a… it's a.. it's yeah, it makes you feel a bit weak'	P17, 680-685		
basically had emotional indigestion for.. coming up to 2 years now, on the whole thing,	P 7, 231-232		
mobility wise, it had a considerable impact for very long time, for months, um, and emotionally as well, um, you know the ability to get up and down, or if I moved too quickly, it would send me off on a pile on the floor in tears, because I couldn't move, it just really hurt.	P 16, 656-659		
, it didn't help that I spent most of last year waiting, on waiting lists, just barely coping ,and waiting, and waiting for support, um, I'm getting it now, but I think it's kind of compounded the trauma of having to kind of, you know postnatally with so much, and trying to hold on through.	P18, 791-795		

so fully healed would mean kind of emotionally and to be in a place where I could consider having more children if that's what we choose to do, at the moment I'm struggling with that yeah fully healed for me would be both physically and emotionally, as much as possible, I know these things leave scars, yeah physically and emotionally, for me not to feel so triggered all the time, been feeling in pilot mode, for nearly 2 years now.	P19, 804-806 P19, 809-812		
'and then like your other children are wanting to come for hugs and cuddles, but you still got that very sore stomach, you can't cuddle them like you want to, I think there's a lot of guilt involved, in not being able to do what you want to do.' 'Yeah, it's crazy, but um as time went on I was able to do little things, like maybe by 3 weeks, past postpartum, I was able to do little bits in the house. It was still not much, and um, you know, that's hard as well because I like my house a certain way, and my partner doesn't have the same mindset, so you know, it's difficult when you like to be in a clean home, um, but you can't physically do it yourself, and that, that, you know, that ends up affecting your mental health as well' So it just wasn't really fair on him because he was very..I guess he felt unsafe, because I'm his primary care giver, and I just couldn't do things with him that I would normally do, you know, I can't, I couldn't play with him, I couldn't help him with things.. When he.. I wasn't really there in the beginning, obviously my partner was there, fine, but I'm his Mum you know (I: Yeah), yeah, like it really made him upset and he cried a lot when I was in pain, um.. I mean now things are fine, but yeah I think that would have really affected him. 'like I can't provide for my children the way I should, so it set me with a lot of like Mum guilt, erm but especially to my daughter, because she was almost 3 and you know, she wanted to like play and you know, she didn't expect me to be in that	P11, 418-422 P8, 326-333 P9, 378-386 P7, 220-227	Family dynamics- other kids/ household chores	

condition, she was obviously not aware, she's used to me being mobile and things, so she just couldn't understand and it made me feel really guilty towards her more than the baby at the time, erm, because you know, she required more from me'			
I feel like that time really affected me and my daughters relationship, a little bit, erm because she was so used to it being like just me and her, in the house the whole time, it kind of uprooted her, even though she was like you know Mummy's got a baby now, and she watched the belly grow and was like- Mummy's having a baby, and all of that, and then the baby's here, she came to visit me in the hospital, um, obviously she couldn't comprehend that Mummy wasn't going to be able to do things she normally does, um, so it upset her quite a bit when I had to keep saying like- we can't do this darling, maybe we'll just sit and play a game, um instead of like doing like a moving activity, um so that was quite upsetting, um, in terms of mine and hers relationship'	P10, 378-390		
'but in that time period where I was like less mobile and stuff, she..We kind of struggled a little bit, like she was excited over her baby brother, but she.. you know, she would get upset when I couldn't do certain things with her.'	P11, 403-107		
? Like you can see they're tired and drained ,like especially my Mum because she's older, um, and she's supporting my children and then plus me on top, um, and I could see like she's tired, you know, she's struggling herself, and it's like they're my children, and it's not for you to have to like be exhausted over, kind of thing?	P13, 491-496		
and they were really looking after me, and.. I'm the eldest child and I you know.. you know, I think when you're the eldest you don't get much looking after, you know the younger kids come before you, so it actually felt really nice, I mean it felt nice to be looked after, erm.. and that was, and they were very happy to look after me (I:ok), erm, so that was a totally different dynamic to our normal dynamic (I: yeah), um, that was yeah, actually that was lovely (laughs) so I was very upset when they left (laughs).	P12, 434-442		

'The first couple of weeks he was off was wonderful and I think it then became a bit more… functional (coughs) after that, but when.. at the evening time, we would try and have even just an hour on the couch together? (I: yep), just watch a little bit of telly and just.. and just have a cuddle really and just try and.. try and mind each other (I: yeah), umm, so I think we were conscious of looking after each other and conscious of not just erm, of falling into trap of just being existing'	P12, 450-457		
I mean we have quite a good relationship where like we split things 50-50 and stuff, so um, yeah,so it didn't really have a negative impact on us and stuff, like he would just crack on and do what needs to be done, so um, so I didn't have to worry about you know.. cleaning the house, or what not, so yeah.	P15, 518-522		
my fiancé, um, I'm lucky that my fiancé got the memo that it's the 21st century and men need to be hands on (I:laughs), he's a very lovely guy and adores being with the children, so um, I relied heavily on him,	P7, 251-254		
my relationship with my second child, who is now 2 is um, quite distant from his end, so he's very much, he very much thinks that the maternal figure is my fiancé, the Dad, so he even for example, if we're reading a book, and there's a Mummy and baby, he'll say- Daddy and baby (I: ok, mmm hmm), he doesn't quite understand that the Mummy isn't the Mummy, which on one hand is amazing that he's got such a close connection with his, with his Daddy, but you know that really, you know, pulls on my heart strings that because I couldn't be there for him, um, for those reasons, you know it's had an impact on our relationship now.	P8, 286-295		
, that makes me really sad that he, you know, he doesn't want to come to me, he wants to go to his Daddy all the time, so I suppose um, you know, when I was recovering you know, he wanted me to pick him up and I said – I can't pick you up, you have to go to Daddy, so that's, that's a big dynamic change where, um, I wasn't Mummy to him how I should have been mummy to him,	P8, 298-304		

, with (wife) I mean we, we've always worked really well together as a team, um and, it really.. you know it was hard, but because of that we were able.. you know really strengthened us in many ways, as team, but it also really stretched us, so both of us were just so depleted	P17, 741-745		
' so I think it has a big impact on them as well 'cos they can't see you, they know you're in a lot of pain, and they want to help you with the baby and then they can't do that 'cos you're in a hospital and then they can't come and help you with it.' 'Well, I think they have to do a lot more, don't they, um, it's just harder to juggle everything, you're a bit more out of action, and so then you feel bad that you're not able to do certain things, and they want to look after you and help you, probably feeling a bit like helpless 'cos they can't.. they can do things practically to help you, like help you with the baby, around the house, but they can't actually help you erm, with how you're feeling and making it better.' 'my husband was like really pale, um and he was just watching my heart rate, my blood pressure, um and I was looking at him and he was like- the baby will be fine, I'm worried about you' and it made me feel good because obviously I have someone I trust, dealing with it? we kept on cleaning the wound for.. probably 6 weeks? Or until it was all healed properly? (I:mmm), obviously we kept on like um, after I had my shower, so my husband would dab it and clean it again to make sure it's all clean and dry, so um, us doing that, I guess made.. Made the wound heal faster? Um, I think I managed quite well, um, because I got the support from my husband so um, yeah, everything was alright. I trusted my husbands.. My husband's instinct to be honest (I: oh ok), yeah, so if he said to me about, if he said that it's um, it's getting better so I just go with that, or if he says that um, there's something wrong with it then he will just keep an eye on it	P11, p443-447 P12, 466-473 P5, 143-145 P5, 155-156 P8, 234-239 P8, 259-260 P11, 374-380	Role of family in postnatal/ Social support (practical v emotional)	

and then um, if it was getting worse with it then we get um, the midwife involved, um, if not then we just.. keep an eye on it.			
'I think the hard bit is once, you know, once your husband has the two weeks off and then they go back to work and it's.. it does fall quite quickly back to you to do a lot of the chores if you like, the night feeding and the getting up and those things, erm.. yeah so I think before you are ready to take on a lot more you're all of a sudden have to take on a lot more, and especially because the c-section wound hasn't healed, maybe as well as it could have after 2 weeks, and you feel not well from the infection,'	P12, 480-487	Feeling dependent (family)	
, 'but yeah I just couldn't do anything much, he had to shower me, um, and it was.. it was just a lot of pain for a long time'.	P6, 231-233		
which is quite upsetting, to do something simple thing like picking him up when he's crying, I had to like, be like, erm, you know, my Mum or my sister, whoever was there at the time, be like' can you.. can you, pick him up and give him to me', 'can you get me this', 'can you get me that', so I can just like feed him? On me, you know, so it just felt like I can't provide for him the way in which I want to.'	P6, 170-176		
she helped me get in and like sort of like gave me a wash and like you know, sorted me out, but it's just, I felt so vulnerable (I: yeah),like.. it's the whole, like can't explain, but it just makes you feel so vulnerable and like helpless towards yourself, and you're just sort of standing there, like and someone else is taking control over the things that you do for yourself, it's a really like horrible experience, you know?.. Like the most vulnerable thing, like you're just standing there naked you know and needing assistance, so that was.. That was really hard to bear, for like, for myself, like my own feelings, you know, um and my own body'	P9, 335-345		
.. it just felt like these are the basic things you should be doing for yourself, it caused me so much discomfort and pain, I just couldn't do it, so it was like.. But	P9, 347-355		

then I also didn't want to feel dirty you know? So it was like, need the help.. So it was like I need the help, I don't really have the option, I don't wanna sit here without washing and stuff, but at the same time in having that help, it was just really vulnerable… it makes you feel like.. you're very childlike, you know? Like um, like you're not an adult being able to care for yourself.			
'once you're there you're like- my goodness, this cost so much money, and not even just yourself, it can be the people that are supporting you also, probably spending loads of money, you know in helping you and supporting you, and you don't really realise like the financial aspect, at the time,'	P12, 471-476		
, but you don't think about the extent of the support you're asking from people you know? Because it's a lot of support you're asking for.	P13, 481-483		
I was very grateful, but it does make you feel like.. I know it's your family, and they don't obviously feel like grudgeful or anything, but you start to feel like you're taking the mick?	P13, 488-491		
'and then especially when my husband went back to work after 2 weeks, I couldn't carry.. that made me feel very erm.. dependent (I: mm), which I didn't like, and I'm not used to, I've always been very independent. So that made me feel.. it did.. it made me feel vulnerable, dependent, err, and you're so sleep deprived.'	P7, 241-244		
and he was working from home… so he was still going to be at home, but I felt like this cocoon was being taken away from me (I:mm hmm), and I couldn't do all the things that I normally do, and what was I going to do without him?	P7, 255-259		
and it was lockdown, so there was nothing open, there was no coffee shops open, I couldn't go anywhere, or if I needed to wee (I: yeah), there was nowhere to go (laughs), and I was like- (husband) you have to come now (I: mm), and that was difficult, that was definitely.. that was erm, that was strained, definitely.	P12, 468-473		

she literally had to help me with absolutely everything, I couldn't.. I basically couldn't move,	P13, 528-530		
'I mean you get like a little leaflet… A little like.. Seems it was printed about 50 years ago, this little bit of leaflet. But again you haven't got time to read that, to read through it you or your husband, you need like.. Some information that's very clear and easy, for somebody to actually tell you, nobody in the hospital says 'right, here's the surgery you had, and this is how it might impact on your body, and these are the things you need to look out for. You shouldn't do x, y and..' you know there's this little rumour that goes around of don't drive for six weeks, but there no… There's no.. Somebody needs to tell people, I mean, there's a lot of people that will be going to hospital you know.. Where English isn't their first language, so to give them a small leaflet with lots and lots of words in it about it all, and that's not helpful,	P14, 532-545	Women's informational / support needs	
'Everyone seems to have different types of stitches so it would be interesting to know, you know, if one isn't like what I had, not dissolving, what do you do then? Like do you, you know, is it something that you contact your health visitor? Is it do you need to go to your GP? What kind of things are you looking out for to know that it's actually erm, a more serious infection that needs some antibiotics,'	P14, 560-566		
'that there should be a lot more support um, mentally and physically, because, you know, it is major surgery, and sometimes it can be very traumatic, there should be a service where you can perhaps talk to someone, um.. Through the hospital, there should be some sort of maybe a.. Counselling service, so you can talk through your experience, um, and again, they should be really vigilant and aware of the wounds, and the kind of pain, and the issues and difficulties that they could leave behind, there should be services there for that and more support.'	P15, 596-605		
'people need to be heard, about what they want and how things are going to affect them,			

‘because they usually talk about like, smooth sailing pregnancies and you know, they don’t really go into depth of how it can go wrong (I: um, yep, yep), you know, like they will say obviously there’s a risk of etcetera, but they don’t .. I feel like obviously they you know, don’t want to ruin people’s vibes and keep positivity around their pregnancies obviously, but there’s like no… um.. real sense of like- oh, this may go terribly wrong and I might need extra support, I might need extra this or, you know? Type of thing, like things like that’	P15, 617-619 P13, 515-523		
‘So they said it can make the contractions um, worse and more frequent, so it doesn’t feel like you’re getting a break in between? (I: ok), but that was explained to me afterwards, it wasn’t explained, you know, in all the midwives appointments I had up leading up to the birth, so I wasn’t prepared for like little things like that, you know, let alone knowing, thinking- oh I might need extra family support or whatever.’	P14, 559-566		
‘more face-to-face care, more er, more caesarean sections specific aftercare? (I:mm), you know, so you have this huge surgery, em.. er, you know, we would see you on this many days, this is what you do if something doesn’t feel right, um, you know there was no usual safety netting, erm, there was no plan, it was always a bit like- ok we’ll see if we can squeeze you in there and then..it would just be a phone call.’	P20, 813-820		
, if things were better you’d hope that you’d have a proper, you know, advice pamphlet, or something to go home with, to..how do you care for your wound (I: yeah), you can’t.. how long is it expected to last for? I didn’t have a clue about any of those, ideally you’d have a little website wouldn’t you, or a help session or something, where it said.. Where it went into information about post c-section healing.	P11, 437-441		
I think it’s giving Mums potential scenarios of what could happen ,and if it does happen, what you should do, um, like you get given a c-section leaflet but it doesn’t			

go into that kind of information there, it's quite surface area, so.. you know, if you're feeling like this once you've had your c-section on day 5, then you know, ask this, or ask your health visitor, or.. really give you guidance on to what questions you should be asking, and um, how you should best look after it, um, what limits you should do, worst case scenario, best case scenario, um.. maybe even um, somebody that you can ring, a support line, um, or you know a..somebody who's been, you know, who knows what it's like to go through that. but I didn't know anybody who had gone through it, so it's very much just um, guesswork really, um, whereas if that happens, you know, if your c-section scar gets infected or if it's bleeding a lot for a long period of time, you should be given a leaflet with information about how best to care for it, and what you need to be careful about and what is the red, you know, what's a red alert if it gets worse, you know, what are the indicators of that, but there's nothing like that, so.. and they did all the kind of checks and this is what you need to look out for, and.. talked through all the things that I needed to do, they didn't talk me though anything like um, I knew I wasn't supposed to drive, but they didn't say anything about not being able to drive, they didn't say anything about how to get myself up and down, making a plan with, you know, the ability to kind of really plan it, and the home care, you know even with your friends and family, kind of what that might look like, er, pain relief (laughs), don't send people home with no pain relief after a major surgery, it's just not ok	P14, 543-545 P18, 734-744 P18, 748-755 P12, 473-478 P22, 958-962		
I think there's no time, and I know they're under a lot of pressure and there's not a lot staff available, but they should come and talk to you properly about the surgery you've had, and how you need to look after yourself when you get out from the hospital and what problems you could face and then what to do if…' 'I know there's a.. I suppose the problem is you do get the people that ring up and there's nothing wrong, so if you swab everyone there's a cost implement, you	P14, 545-550 P14, 575-580	Negotiating staff care	

know, to that, but.. I don't know what the answer is, really, but I think a lot more information about what you should be looking out for, what becomes a concern'			
but also I suppose having that healthcare background and understanding, I knew the pressure they were under, I didn't have unrealistic expectations but at the same time, I was.. I was looking for more and not able to get it.	P20, 805-808		
: To be honest, um, when I had (baby) it was beginning of lockdown and what not, so the midwives they were not really sure what was going on? (I: mm), so um, I think they tried their best to be honest, they were quite um, helpful, apart from obviously not taking care of my wound (I: yep), but apart from that they were really helpful	P13, 441-446		
I mean it's mainly down.. down to the smell, I mean you know.. They could have.. they should have cleaned it, but.. I mean you can't win isn't it when you go to hospital.	P13, 455-458		
, I should have got my wound.. but the rest, everything was fine, like they were there for me, like I said, they couldn't be there 24/7, but erm, I think for 2 nights or 3 nights they offered to look after (baby) so that I can have a nap, you know (I:mm), so to me that's something, I mean, yes, my wound is major, but it is what it is ,and again because it was beginning of lockdown, so .. who knows how they were feeling? You know, they are working and they didn't know a thing about Covid and new rules were coming, so.. yeah..	P14, 485-493		
, I mean I think the postnataly, the heath visitor, and the doctor had taken it seriously in terms of checking it and whatever else, but then they can't really do anything when.. it.. you know, it seems and feels fine, um and.. it's just tricky, because it a very non.. you know, everybody's recovery is different, you know, they say.. that's all they can say really, is everyone's different and some people it's, you know, they spring back, and other people it can take a long time	P17, 702-709		

..It was more when I was like lying down and then getting up was the biggest struggle, so I kind of set up in my bedroom like loads of pillows and stuff, I sort of slept sitting up, for a while I bought like ready made bottles, and sterilised bottles and put them all in the bed with me, next to me and the nappies and stuff, like so I could literally just in the night, pick him up and put him on the bed and like do everything without having to move, erm so.. Although it was horrible I kind of made it work to the best I could given the circumstance'	P6, 204-213	Coping strategies (survival mode/ just get on with it)	
but I would sort of like, you know, just stay in bed or on the sofa and just have everything prepped, in order to like survive then. It was a very, time of like, made me feel, erm, like not adequate, you know?	P6, 216-219		
On one sense it felt like a blur because the days just rolled into other days	P9, 319-320		
I think I was quite numb, I was just… I was just on autopilot. I just..I had this little baby and I was just kind of fascinated but not, I don't think I was truly, actually understanding what was going on.	P6, 180-183		
I think I just got through it, because again, when I.. when I think about it, it all still feels quite.. and maybe it's the same for every parent Clemmie, I don't know, I think I was just on autopilot (I:mm), I think I was just.. doing, and.. and just learning, and trying to keep this little baby alive, er.. And I think I probably, I think.. I think I was just in a.. whirlwind	P7, 247-252		
.. yeah, this part of my body just that was causing a lot of grief, yeah.. it felt.. it felt difficult but at the same time I was like I don't have time for this, I have to just get on with it.	P8, 296-299		
so yeah it felt like another thing, but again, you just, you just put yourself kind of to the side don't you?	P9, 331-333		

'but at the same time you're so tired and you're just trying to.. you're just trying to get through it all, and keep your baby alive (laughs)…because you are, you're as you said, just in survival mode,	P21, 823-827		
, but because it was lockdown you had kids, had kids at home, there was no room for any emotions really as far as I went (I: mm), so you just carried on, but um, just really disheartening and just yeah.. hopeless really.	P7, 242-245		
so I just.. you know, just took a practical sense of it all, we didn't leave.. I actually didn't step outside of my backdoor, apart from to go to the hospital those 2, 3 times, I didn't actually leave the house, even to go for a walk and everything, for 6 weeks (I:mm hmm), even step out of that book door, I didn't go on a school run, I didn't go to the shops, I didn't do anything.. I didn't even go for a little walk, you know, with the baby, I just stayed inside, and I stayed sat on that chair, because I was so conscious that I was still bleeding and I was worrying that if I started moving around, it would just prolong my healing?	P11, 424-433		
), I think that it's just a tangled web, of emotions, when you're.. When it's that early on, you're caring for a newborn, um your recovery is rubbish, so.. you just feel, you're just in survival mode, it's as simple as that, it's just pure survival at that.. there's no quality of life, at all, you just feel like- if I could just put one foot in front of the other, just get through today, tomorrow is one step closer to recovery,	P13, 514-520		
but at the same time I haven't really had much time to think about myself this past year, um, I've just had to crack on and be a Mum	P20, 790-792		
so I was just trying to soldier on, thinking, you know, it's the norm	P13, 538-539		
so we just held on, and held on, and held on, and tried harder, and tried harder and it just felt like I was completely failing at everything	P15, 612-614		

even now, still firefighting, somewhat, in terms of trying to keep on top of things and coping,	P18, 745-747		
'basically after the GPs had like no, kind of interest after I had got my antibiotics, I rang them to ask them you know, about still having pain a couple of months ago and that's when I was told 'what did you expect?', so I knew that wasn't really going to go much further, so I kind of gave up with that,'	P16, 638-642	Feeling abandoned/ lack of interest from HCP	
'I think there should be you know, even when I went for my six week check, I had to ask for them to look at my scar, and she's very much like eye rolling at having to do that,'	P16, 651-653		
um they gave me a painkiller and I sort of just stayed there for what felt like hours, I'm not sure how long it was, um and then they came back and done like bloods and whatever and just left me in the bed again, um, and just sort of left me just lying there	P7, 286-289		
''the midwife changed my son, changed his nappy, got him dressed and just gave him to me, and turned the lights off (laughs), I was like- oh my God, what do I do? (Laughs).	P6, 175-178		
so the midwives were like nice and everything, but obviously they couldn't deal with me 24/7, it was hard, yeah, obviously you're in pain, baby's crying, you want to do several things but you can't.. it was..yeah..	P4, 115-118		
my tummy muscles won't go back together, because of this big scar mass that I've got (I:mm hmm), um so I'm kind of stuck now, unless I come and pay privately, and go and have it removed, um, the NHS don't really want anything else to do with it unfortunately.	P6, 183-187		
So all in all, as does any Mum, you know, you get um, pushed to the bottom of the pile,	P6, 203-204		

it was already a very black, blue and bruised area, but then it was going really black and really oozy (:; mm hmm), and when I said you know, it's looking.. I think that it's infected, it's hurting, and it looks.. and they said- oh well, yeah, it could be infected, but um.. it might not.. don't know (I:ok), so I said-well, can we just treat it like it is infected? And then you know, I can make sure that I'm not going to get more poorly with this? You know, the last thing I want is sepsis, you know like.. So like (mimic voice)- oh yeah, right, sure, you know, I just felt like I was being handled by children, basically no, the health visitor goes through the standard one at 6 weeks, um, but they don't want.. they don't want to hear it, they just want to take it off and off you park	P12, 464-472 P13, 499-501		
'I..j just feel the.. the.. dressing over the wound, there's a scar, it was really big, it was very long, you know for my first one it was very small, so I said to the Doctor when they came, I said- why is it so big? And she said- Oh I don't know, I need to check. So it's like they did things and they didn't even tell me what was going on, which really annoyed me' 'my sister who was in the birth with me, I think she said that she asked them sort of out of my earshot, erm, what's sort of happening, why is it taking so long you know, erm and they said they're like having a few complications in stitching me back up so it's taking them longer, I don't actually know what was the problem, erm, but that's what they relayed to my sister and they sort of downplayed it to me, well I suppose obviously they didn't want me to become erm, in even more of a state.' It still sparked some anxiety, to be like is there something they're keeping from me? And stuff, you know? they didn't even give a reason why, I think it can be blood vessels or you know, something, er, but you panic that it's um, like your bladders haemorrhaging or your	P5, 186-192 P4, 122-130 P5, 146-147 P10, 361-366	Mother not being informed by HCP (kept in the dark)	

wounds ripped open, or you know, the 'cos you know I'm not a doctor, and I don't know what's normal, or what's not normal, so it's like fear of the unknown. really quite scary, because nobody was giving me advice on what to do, they were just saying to put a sanitary pad on it, you know, that's all I had to go at, you know, there was no advice around there, , I think Doctors are very good at, just having a straight face, they don't react do they? That's part of their… that's part of what they do isn't it? So they don't alarm the patient, but I.. I do remember them constantly having little chats in the corner, and hearing things about how.. You know- ooh, it doesn't look quite right, and (makes whispering sounds), things like that, so I know that it wasn't right. , but you just feel in despair, and you just don't know when it's going to stop and that's the thing, if somebody said to me- you know, with a bleed like this, it's anticipated that it could last up to 6, 7 weeks, so just be prepared there, you know, don't panic, I've never had, nobody ever had that kind of conversation with me (I:mm mm), um, it was just like brushed off, and.. and..so you just feel a little bit worthless and um, that you have no importance.	P11, 434-437 P12, 480-486 P13, 520-526		

Appendix 10C- Sorting of themes from emergent to master

Master themes	Sub-ordinate themes	Emergent themes
Tied to that event': healing physical and emotional wounds	Reganing control over an unpreditable body	Notes: link between birth and healing (emotipnal and physical healing), timeline of events- wounded body (immediate postnatal) , Dealing with an altered body/ negative body image ,Loss of control over postnatal body, never ending healing/ dealing with an unpredictable body
	How things should have been	comparison to social media, comparison to other Mums, Mismatch in birth and postnatal expectations/ feeling unprepared (new mum role attainment) . Notes: sense of disconnect
	Making sense of the unexpected	Touchpoints/ how things could have been different, bodily v medical failing. Notes: making sense of recovery (how it got to that point/ how things could have been avoided). Womes information seeking/ knowledge acquisition.
The 'good mother' and the 'good patient': negotiating being a carer and being cared for	The invisible postnatal Mum; having the 'easy way out'	Notes:Societal views of CS (the easy way out) , feeling supported, Not being listened to/ taken seriously by HCP ,Feeling isolated/ like an anomaly , Safe delivery trade off , Feeling abandoned/ lack of interest from HCP, Mother not beign informed by HCP, HCP underminign wound impact, Feeling dismissed during Covid-19, negotiating staff care
	Mothering the Mother: altered household roles	negotating maternal/self-identitiy, Role of family in practical v emotional support, Family dynamics- other kids/ chores, Feeling dependent/ like a burden on family , isolation during Covid
Adjusting to a new normality	Living in survival mode	regaining normality, Impact on role/ Mum identity/ self identity, survival mode. Note: practical and emotional! Just getting on with it/ autopilot
	Healing as a return to normality	Healing as loss of pain/ scar sensations, Healing as resumption of normal roles/ activities, dealing with an altered body, long term impact of the wounded body

10 D- participant quote table

Participant	Tied to that event': healing physical and emotional wounds			The 'good mother' and the 'good patient': negotiating being a carer and being cared for		Adjusting to a new normality	
	Regaining control over an unpredictable body	How things should have been	Making sense of the unexpected	The invisible postnatal Mum: having the 'easy way out'	Mothering the Mother: alteretd household roles	Living in survival mode	Healing as a return to normality
Charlotte	That was my point.. how long am I supposed to take lots of Neurofen and things for it, you know, is it something that’s ok to take for years to come or like, why can’t you look at fixes?' (p9.226-339)	‘I think it’s.. you are.. You’re frustrated and sad because you want to.. you don’t want to be not doing what you.. when you’ve just had a baby, and you want to be going on a nice walk with them in their new pram, and enjoying things and going out places, but you	‘Everyone seems to have different types of stitches so it would be interesting to know, you know, if one isn’t like what I had, not dissolving, what do you do then? Like do you, you know, is it something that you contact your health visitor? Is it do you need to go to your GP? What kind of things are you looking out for to know that it’s actually erm, a	‘Well the doctors were just like ‘well it’s just one of those things, you’re healing’ and I was thinking- well it shouldn’t really be one of those things, it would be nice to find out, to know exactly what the problem might be.’ (p7, 225-228)	‘and then like your other children are wanting to come for hugs and cuddles, but you still got that very sore stomach, you can’t cuddle them like you want to, I think there’s a lot of guilt involved, in not being able to do what you want to do.’ (p11, 418-422)	‘and your hormones all over the place especially, and then you’re tired.. I think it makes all of that a lot harder, the usual once you’ve given birth kind of hormone fluctuations, and the tiredness and lack of sleep, and then you throw that in as well, the wound and then it not healing, and the pain, it just	‘It is tender, I mean it is seven months down the line, but if you kind of catch it funny it’s.. you know it’s still not healed properly, or something’s not quite right, and it’s almost like you know that scar tissue doesn’t go away, it’s not.. it isn’t a

		know, you can't do those' (p11, 392-396)	more serious infection that needs some antiobiotics,' (p14, 560)			makes you so much more.. I don't know, I suppose a lot more miserable, a lot less able to cope with certain things, erm…It's harder to feel a bit more.. I don't know how to explain it…' (p11, 400-408)	case of time heals it, it's always that horrible.. It's that lumpy, hard tissue underneath the scar.' (p8, 313-318)
Amanda	''It was agony, it was so much worse than the first, I mean for 2 and a half weeks I was waking up in the night crying, you know, just begging my partner to get the um the painkillers, because it was that bad, like I've never experienced anything like it, and you know, I	'I felt like everything I was doing wasn't good enough, you know, because everything just wasn't right. I had.. I had something in my mind of what I wanted, and that was to have a vaginal birth, and to be able to walk around, look after my older	and when I was waiting in (hospital name), my VBAC team was there, and I just, I didn't really realise you know when the head of midwifery came to me and said- look, we don't have any beds for you, it's manic, but you can go to (name of another hospital), and I just said 'yeah, ok I'll go there', but I guess, I just didn't really	'You know, the thing is you don't really feel heard when you say about caesarean, because for some reason people seem to think it's the easy way out, or- oh, it's so much better that you had a C-section because your baby was so big, you know you must be so happy, and it's like well.. You know the Doctors were saying that when I was going to the Doctors surgery saying that I was upset about it, they was	'So it just wasn't really fair on him because he was very..I guess he felt unsafe, because I'm his primary care giver, and I just couldn't do things with him that I would normally do, you know, I can't, I couldn't play with him, I couldn't help him with things.. When he.. I wasn't really		I think it's gonna take.. Probably up to a year for it to completely heal, um.. For me to be able to do like the normal thing I did before' (p7, 293-295)

was trying to breastfeed, and it was just.. It was just crazy, it was just really, really hard and really, really painful, I couldn't walk without feeling like I was going to faint, um, it took maybe 3 weeks before I could actually walk around the block, without feeling like I was going to faint, I felt very weak for a long time.' (p5, 199-208)	child, you know, I know for some vaginal births it's not like that, but for the vast majority of what I researched is that normally a vaginal birth allows you to have quite a normal life quickly afterwards, you know?' (p7, 410-414)	realise,um, you know how it will be at the time,' (p15, 609-612)	saying- Oh no, Doctors don't do it for no reason, you know there must have been a reason, it's what's best for you, bla, bla, bla' (p6, 250-260)	there in the beginning, obviously my partner was there, fine, but I'm his Mum you know (I: Yeah), yeah, like it really made him upset and he cried a lot when I was in pain, um.. I mean now things are fine, but yeah I think that would have really affected him.' (p.9, 378-386)		

Sarah	In terms of the pain it was scary, because I didn't know what was happening to me, but also it was horrible because, I had to leave my newborn baby with my Mum, because obviously I had to go by myself, I couldn't obviously take the children, because I couldn't really help them at the time, I couldn't even help myself. erm, but it was horrible, just to say bye to my newborn baby, like he's like a week and a bit old, you know, um, I wouldn't have	'So with my daughters, first pregnancy, it was complicated throughout the whole pregnancy, and the birth and then like after the birth, whereas with erm the most recent child, all the pregnancy was all straightforward, so I did.. I had more hope I suppose this time round to be able to do things for him without having to struggle' (p6, 179-184)	' when they went in to get the baby out, erm, they then, er, took longer than they predicted to perform the surgery due to there being damage inside so they struggled to stitch me back up, erm, because there was damage from the previous birth' (p2, 45-52)	I just feel a bit like.. just because it wasn't an emergency c-section, doesn't mean that it's not traumatic in other ways (I: mm, yeah), you know, like, as in terms of like the healing, infection, or.. You know, being discharged after you come out of hospital, all of these things, it doesn't take away the trauma or how you feel, as like a Mum (I: mm hmm), you know, being like debilitated or whatever the words is, do you know what I mean? Like from being able to do your job, that still causes trauma, but I think the reason they didn't do all those things is because it was a planned C-section if 'm honest, thinking about it now, um, that they probably have those service for people who have emergency c-	'like I can't provide for my children the way I should, so it set me with a lot of like Mum guilt, erm but especially to my daughter, because she was almost 3 and you know, she wanted to like play and you know, she didn't expect me to be in that condition, she was obviously not aware, she's used to me being mobile and things, so she just couldn't understand and it made me feel really guilty towards her more than the baby at the time, erm, because you know, she	but I would sort of like, you know, just stay in bed or on the sofa and just have everything prepped, in order to like survive then. It was a very, time of like, made me feel, erm, like not adequate, you know? (p.6, 204-213)	'It's just uncomfortable, like.. it feels like pins and needles but not, and if you like sort of touch that area it's just a weird sensation, um, so like if you're creaming your body and like whatever, it's just like such a weird sensation and I feel quite cringe about it, erm, I don't think about it on a daily basis, but you know, sometimes it's like I'm creaming my skin or something and I'll be like-

	left him of my own accord, and that like, at that early on in his life, so that was really horrible,' (p7, 253-262)			sections, but the manner in which.. you know, infections, and going back to hospital and pain and stuff like that, it doesn't take it away from it being traumatic, so they probably should look at more specifically the context of the labour you know, because even people that have like natural births, they may have a traumatic experience and they're getting overlooked too, you know?' (p.18, 707-717)	required more from me'		ugh' (p19, 769-775)
Maura	I've never experienced pain like it, it was like a hot poker, every single time, the whole way through m.. my stomach, it was excruciating, and it wouldn't just go away, it	because I had a fantastic first trimester, I felt really strong, fit, I had lots of energy, I felt great, and then suddenly at the drop of a hat I was crawling (laughs) around up the	and I remember thinking how come no body ever said that about a section? You know, you didn't see anything like that, because it was so painful for so long. (p10, 346-366)	he made me feel like I was a bit of a nuisance (I: mm hmm), like silly woman, you know, what are you talking about (laughs), it's fine, you know, it's fine, oh yeah, it looks fine, but he barely glanced at it (I:mm yeah), and I was just like- oh? (laughs) (p19, 767-770)	'and they were really looking after me, and.. I'm the eldest child and I you know.. you know, I think when you're the eldest you don't get much looking after, you know the younger kids	'but at the same time you're so tired and you're just trying to.. you're just trying to get through it all, and keep your baby alive (laughs)…because you are, you're as you said, just in	'I think if I went back running again (I:mm hmm), I think I would feel like that was.. in my body being my own again….. yeah I think if I could get back

	would linger for maybe 15, 20 seconds, (I:mm) and that same intensity, and that lasted.. God that lasted for about a month.' (p6, 208-213)	streets really at just a snail's pace, so that felt…Er, yeah that did make me feel vulnerable' (p7, 229-233)			come before you, so it actually felt really nice, I mean it felt nice to be looked after' (p12, 434)	survival mode' (p.21, 823-827)	running and high impact exercise, I would feel a bit more like myself.' (p18, 715-717)
Tina		'so um, I was ok with it to be honest, I mean, so I knew after the Caesarean I would have to be in bed for like 3 or 6 weeks, and again because I've been this way before so like.. so it wasn't anything new to me? (I:ok), um, yeah, I mean with the oozing, that was kind of like new, but I soon adapted to it' (p8, 267-273)	'so come day 3, um, when the Doctors checked it like obviously I could smell it, smelled like really ugh (makes a disgusted noise), ok, just terrible, and obviously like, in my opinion, like, if like , if like they did have a look at it and rinsed it, or do whatever they were meant to be doing, then it wouldn't be that way?' (p3, 76-81)	I mean it's mainly down.. down to the smell, I mean you know.. They could have.. they should have cleaned it, but.. I mean you can't win isn't it when you go to hospital. (p13, 455-458)	'I mean we have quite a good relationship where like we split things 50-50 and stuff, so um, yeah,so it didn't really have a negative impact on us and stuff, like he would just crack on and do what needs to be done, so um, so I didn't have to worry about you know.. cleaning the house, or what not, so yeah'. (p15, 518)		

Harriet	despair, um sadness, that it's, you know, why is it happening to me? um, just um, felt dirty because it was just blood all the time, um, just really down in the dumps, and I think if I.. wasn't as strong a character as I am, I would have definitely spiralled into postnatal depression, um, for sure, because it was just harrowing, um, and very worrying, you know, you just felt very fragile' (p7, 237-242)	oh God I had no idea that that could happen, like yeah they talk you through- this can happen, da da da, reel of a long list of things, um but yeah there was no.. There was no guidance. No guidelines given on with anything to do with that' (p17, 699-702)	I think my healing was pretty bad because I reacted badly to the epidural, spinal block, whatever it was I had, um, and I know that's not normal' (p20-809-811)	so I went to hospital, and they looked at it, and they just said- oh you know, it's just um, it's just taking a bit of time to heal, it will be fine, um, just go home, so I said-ok, and then, this blood.. pushing out, what do.. what I do with it? Do I.. Do I have to dress it? Do I have to put a plaster or pad on it? They're like- you know what, just put a sanitary pad on it, it will be fine, and I was like- oh..kay' (p5, 152-158)	my relationship with my second child, who is now 2 is um, quite distant from his end, so he's very much, he very much thinks that the maternal figure is my fiancé, the Dad, so he even for example, if we're reading a book, and there's a Mummy and baby, he'll say- Daddy and baby (I: ok, mmm hmm), he doesn't quite understand that the Mummy isn't the Mummy, which on one hand is amazing that he's got such a close connection with his, with his Daddy, but you know that really,	I think that it's just a tangled web, of emotions, when you're.. When it's that early on, you're caring for a newborn, um your recovery is rubbish, so.. you just feel, you're just in survival mode, it's as simple as that, it's just pure survival at that.. there's no quality of life, at all, you just feel like- if I could just put one foot in front of the other, just get through today, tomorrow is one step closer to recovery' (p13, 514-520)	but even now where my.. you know, if I'm stood up, and I press down where my C-section scar is, I have a section about that big, where it's all um, scar tissue (I:mm hmm), it hasn't gone back, nothings soft about it, it's like a brick underneath my skin, and I do, you know, if I cough or if I laugh or anything like that, it hurts' (p5, 172-177)

					you know, pulls on my heart strings that because I couldn't be there for him, um, for those reasons, you know it's had an impact on our relationship now.' (p8, 286-295)		
Lisa	mobility wise, it had a considerable impact for very long time, for months, um, and emotionally as well, um, you know the ability to get up and down, or if I moved too quickly, it would send me off on a pile on the floor in tears,	I didn't expect it to be like a walk in the park and there not to be any pain or whatever, but just to be.. I was just, basically immobile, for such a long time, (p14, 566-569)	because they really have to move a lot faster, and you know, root around a lot more, particularly with having breech, you know' (p17, 718-720)	it didn't help that I spent most of last year waiting, on waiting lists, just barely coping ,and waiting, and waiting for support, um, I'm getting it now, but I think it's kind of compounded the trauma of having to kind of, you know postnatally with so much, and trying to hold on through.' (p18, 791-795)	with (wife) I mean we, we've always worked really well together as a team, um and, it really.. you know it was hard, but because of that we were able.. you know really strengthened us in many ways, as team, but it also really stretched us, so both of us	even now, still firefighting, somewhat, in terms of trying to keep on top of things and coping, (p18: 745). NB. Can also use the word 'soldering on' (p 13,538)	I got to be careful with mobility, with lifting, even now, um, I mean I have a tendency towards things like dungarees and comfy clothes anyway, but um.. yeah I really.. I don't know if I can

because I couldn't move, it just really hurt. (p16, 656-659)				were just so depleted (p17, 741-745)		go back to wearing things like zips and stuff, you know, maybe in time I do, but it just feels very um.. yeah, vulnerable and sensitive and so.. yeah..' (p19, 816-821)

Appendix 11- Participant case studies

(in interview order)

Participant	Individual case study
Charlotte	Charlotte's birth story was unique in that she had planned a Caesarean in order to regain control following previous traumatic births. She attempted a vaginal delivery however when her waters broke earlier than expected, which ultimately led to an emergency CB due to her labour not progressing- a decision Charlotte described as a '*defeated moment*'. Following the birth, Charlotte experienced prolonged pain at her wound site and delayed closure of the wound due to contracting an SSI that she felt was not identified by healthcare staff in a timely manner. At the time of the interview, Charlotte reported self-funding physiotherapy in order to improve Caesarean scar function having felt let down by the NHS care she received. She reflected on how getting further unaffordable laparoscopy treatment may be the only way she can achieve a return to normality by her definition. Charlotte's account reflected themes of agency as she pondered if her situation could have been avoided had she made different decisions, '*it's just one of those'* reflects Charlotte's surmise as to whether control over her postpartum healing trajectory was in her gift at all.

Amanda	Amanda's narrative surrounding living with prolonged surgical wound pain is strongly embedded within her CB story. Having received support to give birth via VBAC, a series of unforeseen events led Amanda to having another unplanned Caesarean instead. Amanda's continued sense of disappointment and loss of agency over her slow healing wound seemingly stems from this birth event. The quote '*Dismissed at very corner'* extracted from her interview summarises the power struggle apparent between Amanda and her healthcare professionals; right from birth to the early postpartum (i.e. not being granted her request of having skin-to-skin contact), ongoing to the recovery period (staff minimising her concerns over surgical wound site pain). From her narrative, it is apparent that relentless surgical wound pain exacerbated feelings of disempowerment and loss of control, for example not being able to fulfil expected roles due to pain contributed towards anguish and frustration concomitant to the birth event. Overall, the interlinked relationship between sense of loss over how things "should" have been during birth and during the postpartum is a key finding in Amanda's narrative.
Sarah	Though Sarah gave birth via a planned Caesarean following a previous complex birth, complications during the procedure and an early SSI resulted in prolonged pain and delayed surgical wound healing. Themes of mitigating power imbalances was also a prevalent finding in Sarah's narrative; there was a sense of begging healthcare staff for help throughout which illustrates Sarah's desperation at having her symptoms taken seriously and a sense that staff viewed her as a "difficult patient". A striking example of this is Sarah's account of being recorded as refusing an injection when she was suffering with pain from an SSI that was missed diagnosed at the time. Power imbalance was also re-occurring in Sarah's narrative as a single Mother seeking family support during her slow recovery, there was sense of her feeling like a burden and transgressing to a childlike state as her Mother took on the main responsibility of caring for her and her children. Similar to Amanda's narrative, Sarah used the term '*smooth sailing'* frequently to convey how her expectations for an easier postpartum recovery contrasted to the reality of her lived experience.
Maura	Maura gave birth via an unplanned Caesarean. Despite her plans for a '*natural*' birth not transpiring, Maura's birth story had positive undertones, this could be due to her reconfiguring safe delivery as her birth priority and the positive interactions she experienced with healthcare staff despite the emergency event. Maura's recovery from prolonged pain and slower closure of the surgical wound was characterised by contrasting experiences of healthcare support and conflicting emotions as she learned to negotiate her novel situation as a first time Mother. For example, in her narrative, Maura often contrasted her sense of dependency and helplessness with her previous identity as a healthy, self-sufficient healthcare professional. This also contrasts

	to Maura's description of being '*cocooned*' with her family while recovering during the pandemic, her use of this word conveying a sense of security and comfort in being cared for.
Tina	Tina opted to give birth via Caesarean as she felt this was a safer option after previously having an unplanned Caesarean. Following birth, Tina experienced a suspected SSI (malodourous wound) followed by slower healing once her surgical staples were removed. Similar to Maura's narrative, Tina's story of recovery is interwoven by varying accounts of interactions with healthcare staff that are often contrasting. Use of terminology such as '*it is what it is'* and '*just rolling with it*' throughout depicts Tina's acceptance over loss of control, both in the sense of length of recovery and managing care expectations during the Covid-19 pandemic. Tina's relationship with her husband was a focal point in her interview; recovery was described as a joint endeavour with her husband taking equal ownership of wound care and home-caring responsibilities.
Harriet	Harriet opted to have a Caesarean procedure due to the risks of spontaneous delivery following previous complicated births. Harriet's surgical wound ruptured during the early postpartum period, resulting in chronic surgical wound bleeding, possible infections and the wound taking longer to close. Similar to Charlotte's narrative, Harriet reflected how historical medical decisions have contributed to her complex healing process. On the other hand, '*hindsight is a wonderful thing'* describes Harriet's assessment of the situation as being unavoidable and unprecedented. Harriet's journey navigating unchartered territory was characterised by a sense of isolation as she conveyed feeling like an anomaly in her recovery and struggled to make herself heard by healthcare staff. Self-identity was again a prevalent theme in Harriet's narrative, for example her identity as a resilient person was often referred to as a protective factor, whilst living with reduced physical ability due to her prolonged healing disrupted identity negotiations related to maternal and self-image domains. Again there are parallels to Charlotte's story in that Harriet reports her journey towards healing is not complete and she may self-fund surgery in order to obtain fuller recovery.
Lisa	The birth event was a dominant feature in Lisa's narrative, as she described her unplanned Caesarean as traumatic and unwanted. Dealing with other unexpected side effects during the postpartum such as prolonged pain and an SSI served to exacerbate the sense that Lisa's motherhood experience was not going as planned, leading to feelings of grief and loss. In this sense, trauma healing was prominent in Lisa's story as she conveyed the link between physical and emotional healing from her Caesarean. For example, impediments to breastfeeding due to wound pain seemed to symbolise overall feelings of failure as a new Mother that stemmed from the CB. Complexities associated with conflicting experiences and emotions were also

	prevalent in Lisa’s narrative; receiving helpful care from some healthcare staff while equally feeling let down by other’s involved in her care. As another example, feeling isolated due to limitations in mobility and Covid-19 regulations, while also describing support from her wife in a tender manner as they circumnavigated the ‘*tricky*’ recovery period together as first time parents.