

INFORMATION TO USERS

The most advanced technology has been used to photograph and reproduce this manuscript from the microfilm master. UMI films the text directly from the original or copy submitted. Thus, some thesis and dissertation copies are in typewriter face, while others may be from any type of computer printer.

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleedthrough, substandard margins, and improper alignment can adversely affect reproduction.

In the unlikely event that the author did not send UMI a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.

Oversize materials (e.g., maps, drawings, charts) are reproduced by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps. Each original is also photographed in one exposure and is included in reduced form at the back of the book. These are also available as one exposure on a standard 35mm slide or as a 17" x 23" black and white photographic print for an additional charge.

Photographs included in the original manuscript have been reproduced xerographically in this copy. Higher quality 6" x 9" black and white photographic prints are available for any photographs or illustrations appearing in this copy for an additional charge. Contact UMI directly to order.

U·M·I

University Microfilms International
A Bell & Howell Information Company
300 North Zeeb Road, Ann Arbor, MI 48106-1346 USA
313/761-4700 800/521-0600

Order Number 9000027

**Cesarean support groups: An exploratory study of a
hospital-based crisis intervention approach**

Graziono, Roberta Kochanczyk, D.S.W.

City University of New York, 1989

Copyright ©1989 by Graziono, Roberta Kochanczyk. All rights reserved.

U·M·I

**300 N. Zeeb Rd.
Ann Arbor, MI 48106**

A

CESAREAN SUPPORT GROUPS: AN EXPLORATORY STUDY OF A
HOSPITAL-BASED CRISIS INTERVENTION APPROACH

by

ROBERTA GRAZIANO

A dissertation submitted to the Graduate Faculty
in Social Welfare in partial fulfillment of the
requirements for the degree of Doctor of Social
Welfare, The City University of New York.

1989

COPYRIGHT BY
ROBERTA GRAZIANO
1989

This manuscript has been read and accepted for the Graduate Faculty in Social Welfare in satisfaction of the dissertation requirement for the degree of Doctor of Social Welfare.

1-12-89
date

Mildred D. Mailick
Chairman of Examining Committee

1/12/89
date

Saul J. Messeri
Executive Officer

Mildred D. Mailick

Phyllis Caroff

Michael J. Smith

Supervisory Committee

The City University of New York

1989

iii

Abstract

CESAREAN SUPPORT GROUPS: AN EXPLORATORY STUDY OF A
HOSPITAL-BASED CRISIS INTERVENTION APPROACH

by

Roberta Graziano

Adviser: Dr. Mildred Mailick

This exploratory study was undertaken to determine whether a program of support would help mothers who had just delivered by Cesarean section to cope better with the physical and emotional stresses of Cesarean birth. The need for special attention to this group of mothers was assessed and a model program of in-hospital support groups was designed and implemented.

A review of relevant research and a needs-assessment study supported the proposition that mothers who deliver by Cesarean section experience both the stresses of major surgery and the role transition to motherhood. However, while much attention is paid to the arrival of the new baby, little consideration has been given to the impact of the surgery or to the recovery process. A structured program which combined group support and information was thought to enable mothers to

cope more effectively with both physiological and psychological stressors.

The program was implemented during 1987 in a large, urban, voluntary hospital. The sample, restricted to mothers who had just delivered by Cesarean section, consisted of fifty women. The program consisted of nineteen group meetings of approximately forty-five minutes each, with the investigator and a nurse as co-leaders.

A formative evaluation of the program indicated that the goal of developing a model for social support, including both mutual aid and education, was substantially achieved. Assessment of the program's effects on participants indicated that the opportunity to share experiences with others was most helpful. Information about the Cesarean surgery and recovery processes, pain management and self-care, common emotional reactions, and planning for the return home, was perceived by the mothers as very important in increasing their ability to cope with physical and emotional stressors.

Findings of the study suggested that knowledge both of systems and of the needs of the target population were essential to success. Future social work program efforts need to consider continuity of care and in-hospital support as important aspects of such programs.

This work is dedicated
in memory of my father,
John Kochanczyk,
who would have been very proud,
and Sophie,
who always knew I could do it.

ACKNOWLEDGMENTS

I would like to express my gratitude to the members of my project committee for their guidance and help. Dr. Mildred Mailick, my chairperson and advisor, gave unstintingly of her time and support, as always. Dr. Michael Smith was generous with his comments and advice, especially with regard to analysis and interpretation of data. Dr. Phyllis Caroff helped to keep the focus on essentials and was most encouraging throughout the entire process, from my entry into the doctoral program to the completion of this project.

To the administration of "East Side Medical Center," I offer thanks for allowing me to conduct the study in their facility. Particular appreciation is directed to the Social Work department, whose administration and support staff facilitated my work, and to the Patient Care Coordinator and staff nurses of the Post-Partum Unit, without whose cooperation the program would have been most difficult to conduct.

Special thanks are offered to a number of individuals--colleagues, associates and friends--whose support and help have made various aspects of the study more manageable: Ellyn Berman, Dorothy Brier, Fern Drillings, Dianne Kane, Roselle Kurland, June Penkus, and Cynthia Wagner.

I am most grateful to other friends and family members for continuing to offer love and support when I was preoccupied and discouraged. Finally, and above all, special thanks to my husband for his scholarly assistance, computer expertise, faith and love.

TABLE OF CONTENTS

ACKNOWLEDGMENTS. vii
 LIST OF TABLES xi

CHAPTER

I. PROBLEM FORMULATION AND REVIEW
 OF RELATED LITERATURE. 1
 Introduction. 1
 Review of the Literature and
 Related Knowledge 7
 Summary 19

II. METHODOLOGY: PROGRAM DESIGN 24
 Introduction 24
 Needs Assessment Study. 27
 Selection and Description of
 Site for Implementation. 39
 Selection of the Sample 43
 Definition of Key Variables 45
 The Cesarean Support
 Group Program. 46
 Data Collection, Monitoring Devices,
 Evaluation Instruments 51

III. IMPLEMENTATION OF THE PROGRAM:
 ISSUES AND CONSEQUENCES. 56
 Introduction. 56
 Alterations in Program Design:
 Systemic Factors. 60
 Summary: Promise and Reality 76

IV. FINDINGS 80
 The Support Groups. 80
 A Description of the Study Sample 80
 The Group Sessions. 81
 Feedback Interviews 82
 Summary of Feedback Interviews. 101

Results of Telephone Interview. . . .	103
Description of the Follow-up Sample	104
Immediate Post-partum Period.	116
At Home	125
Perception of Support Group and Suggestions for the Future	131
Summary of Follow-up Interviews	137
 V. SUMMARY, IMPLICATIONS AND RECOMMENDATIONS	139
Introduction.	139
Expectations and Realities.	139
Pain.	143
Emotions.	147
Support: Partners, Family, Friends and Group.	150
The Family: Partner and Baby	154
Systemic Factors.	161
Conclusion and Implications for Social Work Practice	165
 APPENDICES	
Appendix I. Needs-assessment Study Interview.	172
Appendix II. Feedback Interview Form	177
Appendix III. Follow-up Interview Guide . . .	180
 BIBLIOGRAPHY.	186

LIST OF TABLES

1.	Group Attendance	81
2.	Knowledge and Understanding of Cesarean. . .	84
3.	Cesarean Birth Process	85
4.	Knowledge of Physical Stresses	86
5.	Learning about Physical Stresses	87
6.	Knowledge of Emotional Stresses.	89
7.	Learning about Emotional Stresses.	90
8.	Coping with Physical Stresses.	92
9.	Coping with Emotional Stresses	94
10.	Peer Support	95
11.	Preferred Aspects of Group	96
12.	Feelings Immediately After Delivery.	115
13.	Thoughts and Feelings about Baby	117

CHAPTER I

PROBLEM FORMULATION AND REVIEW OF RELATED LITERATURE

INTRODUCTION: THE PROBLEM

This project was designed to address the health needs of women who have given birth by Cesarean section, an increasing proportion of all new mothers. An unmet need was conceptualized as a lack of support during the initial postpartum period. This period is a critical time during which women must both cope with the stresses of recovering from major surgery and adapt to the major life task of becoming the mother of a new baby. A program innovation, which had a positive impact on both of these components of Cesarean birth, is proposed.

Nature and Scope in Society

In 1970, one out of every twenty babies in the United States was delivered by Cesarean section; by 1983, the most recent year for which figures are available, the Cesarean delivery rate was one in five, or four times higher.¹ (In some hospitals, the rate has risen to as high as 40% of all deliveries.) In fact, by 1988, the delivery of infants by Cesarean section was described as the most common major operation for American women.²

In order to understand the issues which have arisen concerning Cesarean birth and the nationwide increase in its incidence, the National Institutes of

Health (NIH) Consensus Development Task Force considered the reasons for the rise in rates of Cesarean delivery, the question of whether and how Cesarean delivery improves the outcome of various complications of pregnancy, the medical and psychological effects on mother, infant and family, and the economic factors and legal and ethical considerations involved. Increased emphasis on the health of the fetus, advances in technology, improvement in the outcomes of various complications of pregnancy, and a trend toward greater reliance on medical specialists for management of childbirth were all described as factors in the increasing use of Cesarean delivery.³

Among the concerns and drawbacks regarding the use of Cesarean section, the increased psychological and physiological burden of the Cesarean surgery on parents was noted. The Task Force recommended family-centered maternity care to alleviate this burden, by means of improved educational programs, increased discussion of choices, procedures and options, and information exchange in the postoperative and postpartum periods. These were recommended to help families better understand and cope with the Cesarean birth experience. In making them, the Task Force recognized the necessity for attending to "soft" outcomes of pregnancy, including what was termed "psychosocial morbidity"--the possible personal emotional and social distress engendered by the Cesarean birth

process--as well as to the "hard" outcomes of physical morbidity and mortality that have been the traditional measures.⁴ However, there appears to be little follow-up information on "soft outcomes" regarding the way obstetrical technology affects mother and infant,⁵ so that the picture is incomplete. Therefore, the repercussions of medical treatment are difficult to assess, professional decision-making is affected, and there is a widening gap between specialist and clients.

It is possible that interventions focused on psychosocial morbidity may affect outcome; that is, the increased psychological and physiological burden of Cesarean birth might be alleviated if, for example, the mother were helped to understand and cope better with the birth experience in the postoperative and postpartum periods. A program which also includes the gathering of follow-up information might shed new light on the psychosocial aftereffects of Cesarean birth and on the effects of the intervention as well.

Consumer dissatisfaction with medical and hospital policies regarding Cesarean birth has been manifested in two forms, both well-documented in the press as well as in professional journals over the past several years. Outside the health-care system, there has been the development of self-help groups such as C/SEC (Cesarean Support, Education and Concern) and VBAC (Vaginal Birth

After Cesarean). Within the traditional health-care system, there has been increased pressure on hospital administrations, by these groups and others, to allow fathers in the delivery room, and to utilize regional rather than general anaesthesia, during the surgery.

Clearly, a population of mothers who have delivered by Cesarean section exists. This population appears to have special needs, including both those identified by the Task Force (the need for information and education about the Cesarean birth process and its sequelae, and the need for mitigation of psychosocial morbidity) and those advocated for by the abovementioned consumer groups of Cesarean parents. A program which attends to these needs may facilitate both physical and emotional coping following the delivery and during the postpartum period.

Policy Context

Despite the deliberations of the NIH Task Force, there is no nationally agreed-upon policy regarding Cesarean delivery. However, recent developments in national and state cost-containment efforts and in health care financing are sure to have an effect on policies regarding all types of hospital care.

During the last decade, health care costs rose at a rate considerably higher than that of overall inflation, and the federal budget increased the amount reimbursed to

hospitals, due to a reimbursement formula tied to daily rates. In an attempt to contain costs, the Health Care Financing Administration designed and tested (through the Tax Equity and Fiscal Responsibility Act of 1982) the Diagnostic Related Group system of flat-rate payment for each of 468 diagnostic categories, a prospective form of reimbursement which ignores actual length of stay and limits the total inpatient operating costs per discharge.⁶ This system is now being implemented.

New York State now requires hospitals to charge a flat rate for each type of case, regardless of length of stay. Unlike most other states, it applies this payment system to all hospital insurers, rather than just to those insured by Medicare.

Advances in medical and surgical technology, as well as a renewed focus on cost-containment, both point to shorter hospital stays. Hospitals in New York City have already moved toward discharging patients earlier, in response to these new policies, but have resisted bed reductions because more beds mean more income and more opportunities for patient contact for physician-training programs. Bed count and income produced from occupied beds influence the amount hospitals can borrow; therefore, hospitals have a strong financial incentive to maintain a high number of beds, and to keep those beds filled. Under the new reimbursement system, if a hospital

is efficient, it will keep some of the money it saves; if inefficient, it will risk bankruptcy.

The "crunch", then, would seem to be between 1) a shorter length of stay to conform to funding requirements, which leads to beds emptying faster and to a financial incentive--but also to empty beds--and 2) the need to keep beds full while decreasing the length of stay, which could lead to the development of new programs and treatment innovations which would attract patients to a particular hospital in an increasingly competitive market.

The pressure from within the health-care system to limit length of hospital stays may have a negative effect on the new mother's ability to cope with the many physiological and psychological tasks demanded of her, following the complex process of Cesarean birth. The shortened stay may provide insufficient time for the working through of these tasks. An intervention which attends to the needs of Cesarean mothers as defined by the Task Force--that is, the need for information and education about the Cesarean birth process, and the need for lessening the emotional stresses surrounding the surgery and during the postpartum period--might mitigate both the effects of the Cesarean surgery and those of the limited hospital stay, and in fact might promote healing and facilitate discharge.

REVIEW OF THE LITERATURE AND RELATED KNOWLEDGE

Previous Attention to the Issue of Cesarean Birth

Most studies of "psychosocial morbidity" after Cesarean delivery have been in the form of exploratory and/or descriptive investigations by nurses, since it is they who spend the most time observing and caring for these women in the postpartum period. They note the doubts, depression, anxiety, feelings of anger, failure and deprivation often experienced by these mothers. Several representative studies, and their findings, will be discussed with a view toward setting forth issues which bear on the program innovation discussed below.

Affonso and Stichler⁷ interviewed 105 women two to four days postpartum in order to find out their reactions to Cesarean birth. The following feelings, concerns and suggestions were elicited. Though some of them are doubtless common to mothers who have experienced vaginal delivery as well, some would seem to pertain specifically to Cesarean birth:

1. Anxiety and fear for baby and/or self, and fear of surgery.
2. Dissatisfaction, anger or depression about the birth, as it was different from what had been anticipated (i.e., normal delivery, witnessing the birth, husband's participation).
3. Relief at getting the labor over with.

4. Stressful physical environment, altered perceptions of the body, pain, before the physical process.

5. Anxiety about baby's sex, physical status, and seeing the baby, after birth.

6. Need for the presence of a significant person.

7. Physical limitations, distorted perceptions and fantasies, and emotional reactions (relief, disappointment, anger and pain) following surgery.

8. Concerns about ability to handle, breastfeed, relate well to the baby.

9. Concerns about the lengthy recovery period, body image, and sexual functioning.

10. Need for more explanations about what was happening, more physical contact with baby, reassurance, presence of husband, and supportive environment.

These findings were corroborated in a study by Erb et al,⁸ who surveyed parental attitudes toward Cesarean birth and found that Cesarean-birth parents said they wanted more information/education, earlier and longer contact with their infants, more family-centered birth, and more information about the Cesarean birth process beforehand. Interestingly enough, when asked how they coped with their feelings (which ranged from joy and relief through disappointment, guilt and frustration to anger and failure), most parents studied (about 70%)

responded that they coped by talking to their partner, about 50% talked with doctor/hospital staff, and only about 10% talked to the prenatal childbirth educator (though all had attended prenatal classes). This was almost a reverse order in terms of those who know most or least about the Cesarean birth process.

Mercer et al⁹ investigated the relationships of psychosocial and perinatal variables to women's perceptions of birth, in hopes of identifying variables that can predict a positive perception of childbirth and that can therefore permit direction of priorities for optimal care. They found that 1) the woman who has a Cesarean birth will have a less positive perception of her birth experience than the woman delivering vaginally; and 2) the woman who has a mate and/or another person with her in the delivery room will have a more positive perception of her birth experience. Their findings emphasized the importance of support to positive perception of the birth experience.

A study by Marut and Mercer¹⁰ concluded that the surgical method of delivery had been a primary influence on the women's perception of their labor and delivery experiences. In an attempt to replicate and expand on this study, Cranley et al¹¹ compared three groups of women to determine their perceptions of giving birth and the relationship between these perceptions and

the type of anaesthesia used, presence/absence of a significant other at birth, feelings toward the infant, and amount of control and participation in decision-making the women had. As regards the population at hand, they found that those women who, in delivering by Cesarean, felt themselves to have had more control over the birth process (choices about presence of significant others and type of anaesthesia) perceived their experiences more similarly to the group of vaginally-delivered mothers. Reviewing the birth experience early in the postpartum period, particularly when the Cesarean was an emergency procedure, was seen as important.

Marut¹² interviewed a small number of mothers who delivered by unplanned Cesarean to examine the effects of this birth process and to identify the special needs of this population, and found that some women could not integrate the actual labor experience and delivery with what they had planned. The mothers were highly critical of themselves, and needed to be reassured that they had not caused the Cesarean to happen through some negligence, etc. The small amount of time to prepare for surgery led to fear and bewilderment, and the necessity of the surgery brought about feelings of guilt, depression and distress in the mother, who underwent the procedure "for the good of the child".

Marut suggested that the mother is often simply

"not ready" to turn toward her infant due to preoccupation with her own physical and emotional concerns, and the question was raised of whether delayed contact with the infant may affect the mother-child relationship. The implication is that the mother's needs must be met first, including reconstruction of the event, support, etc. Marut emphasized the importance of filling in the gaps and explaining the details of the Cesarean birth experience, and underscored the need for health care personnel to understand the impact of the unmet labor goals and the effect of the loss of autonomy on the mother.

Shearer¹³ adds that post-partum teaching has been shown to lead to significantly more positive feelings about birth, the baby, and physical recovery, and to less use of pain medication.

Other descriptive studies have covered the same ground and made the same recommendations as those noted above. Additional findings in these studies include the following:

1. The self-esteem of Cesarean mothers was significantly lower than that of vaginally-delivered mothers.¹⁴
2. Changes in body image take place in the first few weeks following delivery.¹⁵
3. Conflict between the roles of patient and mother occurs following Cesarean surgery, with concomitant

threat to the woman's psychological status.¹⁶

4. Cesarean delivery has a psychosocial impact on the entire family, with fathers experiencing role failure but also being more involved with their infants.¹⁷

5. Changes in hospital policy can bring about improved family relationships.¹⁸

Cesarean Support Groups

One intervention that seems helpful in the psychological integration of the Cesarean birth experience is that offered by post-discharge Cesarean self-help groups, which provide short-term emotional and informational support to women who have experienced, or anticipate, a Cesarean delivery. They provide a reference group and role models, as well as enabling members to help others; and increase consumer consciousness and control. Many of these groups were formed because the felt needs of Cesarean parents were not being met by existing professional caregivers.

Lipson¹⁹ examined the functions of Cesarean support groups and the experiences of the participants, and found that the information exchanged at meetings helped/allowed members to evaluate the birth experience more objectively, to verbalize and diminish anxiety around being "finished" as a sexual being, to work through anger/guilt/worries about the child and the relationship to the child, including reassurance about bonding, and to

plan for an expected Cesarean birth by presenting options and choices. Information about self-care activities that hasten post-surgical recovery assisted physical healing. Members became more confident and assertive health-care consumers. The group provided them with the ability to use a variety of coping styles to address their worries about not having the "perfect" childbirth and their feelings of disappointment, grief, anger, etc. Coping was improved by the members' ability to use information, to express their feelings in a safe environment, and to reach out to support others.

In another part of the above study, the stages of psychological integration of Cesarean birth, as experienced by participants in Cesarean support groups, were examined. The subjects were all middle- and upper middle-class women, and many were professionals who had established their careers before deciding to have their carefully-planned children. The investigators found that a number of variables, such as birth plan, relationship with doctor, preparation time before surgery, labor, presence of husband, contact with infant, and medical complications, were significant in establishing the meaning of the Cesarean to the individual woman. However, for all the women, cognitive, affective and integrative processes were involved in what Lipson and Tilden²⁰ identified as a "trajectory of resolution" leading to psychological

integration of Cesarean birth, as follows:

1. Immediate post-operative period (21-24 hours)--affective flatness, numbness; acceptance of Cesarean for the safety of the child.
2. Initial postpartum days (until 5-7 days after birth)--disappointment, relief, anger, guilt, envy; detachment with regard to the infant. There is a need to adjust to the birth experience before beginning the experience of motherhood. Physical coping predominates and must be accomplished in addition to coping with the baby. This often leads to the mother feeling overwhelmed. There is a high degree of sensitivity to the amount and quality of support provided during this period.
3. Emerging awareness (until about 8 weeks postpartum)--conflict between infant care and recovery from major surgery. The woman needs to be nurtured; she experiences disappointment in mothering skills, breast-feeding problems, and bonding anxiety. Anger, nightmares, feelings of failure, and self-image problems are characteristic.
4. Intermediate resolution (2 months to 1 year)--intermittent intrapsychic struggle to resolve issues. Memories surface unexpectedly, sometimes followed by rapid repression and denial. Reconstruction becomes more complete; so does awareness and labeling of feelings.

5. Resolution (after 1 year)--feeling of acceptance; placing the Cesarean in the perspective of the rest of the woman's life.

Lipson and Tilden recommended prenatal preparation (a suggestion also supported by Fawcett et al),²¹ a more supportive hospital atmosphere, a family-centered focus in surgery and recovery, placing of Cesarean mothers together postpartum, extra attention by nurses to physical and emotional issues of Cesarean mothers, and support groups that have a program of in-hospital visits as being important factors in facilitating psychological integration. They felt that association with, and support of, other Cesarean mothers was a key factor in postpartum adjustment and emotional recovery, and thought that further research was needed, especially among women of varying social classes and ethnic groups, to determine other factors in the recovery process.

Support, Health Care and Social Work

We have reviewed investigations into the psychological, physiological and social impact of Cesarean birth, studies which are largely exploratory and/or descriptive in nature, provided by nurses who have made specific suggestions and recommendations for the improvement of in-hospital care, as well as pointing up the helpfulness of support groups in facilitating the healing process. Other disciplines have also looked at

the role of support, among them social psychology's subspecialty, health psychology. In a review of studies of social support, Wortman²² found that in a number of well-designed experimental studies, respondents assigned to supportive treatment showed better mental and/or physical health outcomes than control respondents. Patients who participated in interventions involving support (information, attention) showed enhanced self-esteem and feelings of self-efficacy compared with patients in a control group. Verbalizing personal concerns during stressful times can help clarify feelings, develop strategies for dealing with them more effectively and beginning active problem-solving, and evidence is mounting that peer support may be uniquely helpful to those undergoing extreme distress. Through providing information about a situation, or about resources available to an individual, social support, especially that which provides informational and instrumental as well as emotional components, can influence the extent to which a situation is viewed as threatening, and might alter coping mechanisms and suggest new coping strategies to deal with stressful events.

Schwartz²³ conceptualizes situation/transition groups (often labeled "self-help" or "support" groups) as small groups used for "the mutual assistance of those faced with a shared life stress such as medical illness"

(p.744). The groups have several essential features, of which the following are pertinent to the population served by the program:

1. A primary orientation toward helping participants cope more effectively with some shared external event.
2. A trained leader who moderates the sessions.
3. The provision of social support, factual information about the life stress shared by the participants, and an opportunity for emotional interaction with others around the group focus.

The groups make it possible for members to get and to give emotional support, to share concerns, to find that others have the same or similar difficulties, to verbalize and ventilate feelings, and to receive and share information. A situational/transitional group can help participants develop a cognitive framework which can make feelings and reactions understandable, and give meaning to otherwise confusing events. This type of group can also serve a preventative role by supplying a particular population with adequate psychological and sociocultural resources. A group of this kind is usually started in conjunction with an organization or institution, but during the course of the group's existence the leader may perceive that what is helpful to the members may not be helpful to the organization, or vice versa.

Northen²⁴ writes about social workers' use of groups and the effectiveness of supportive social networks in helping cope with illness: the major targets are populations at risk, such as new parents and, among others, persons facing major changes in roles or body-image. Clinical social work in health settings can maximize the availability of intra-, interpersonal and environmental resources for the benefit of clients, especially those whose normal relationships and supports have been disrupted for medical reasons. "These people often suffer from a sense of loss, depression, anxiety, hopelessness, helplessness, low self-esteem, negative self-image, etc." (p.111). Educational, therapeutic, self-help and social change components of group work can be used in health care settings, and treatment can be brief. Katch²⁵ underscores the utility of short-term groups in health care settings, and adds that there is a need, with such groups, for a clear purpose and a population with a strongly identifiable common ground. Lurie and Shulman²⁶ identify a hospital-based self-help group as one way of providing assistance and support in the face of bureaucratic and inflexible health care agencies; this type of group is linked to a specific hospital program, is focused on patient needs, and uses health care professionals to help stimulate and lead the group.

Another view of the professional role in health care is provided by Caputi,²⁷ who proposes a humanistic "Quality of Life" model to combat the often perfunctory and ineffectual medical/technological aspects of a health care system which excludes the psychosocial component of health. Patients need information, understanding of their own condition and how to cope with it, explanations of procedures and choices, responsibility for managing their situations, and enhancement of coping behavior. They need to deal with pain, the hospital environment, and professionals, as well as maintaining emotional balance, a satisfactory self-image, etc. The social worker, in helping to enhance the patient's quality of life, needs to negotiate with the patient, family and health care system, facilitate the patient's communication with the system, and engage in coordination and collaboration with other professionals.

SUMMARY

In the foregoing, 1) the policy underpinnings of the problem of Cesarean birth have been described from both health care and funding vantage points; and 2) previous attempts to understand and deal with the problem, including medical/nursing, health psychology, and social work/support group components, have been investigated, in order to provide a background for the program presented

herein: in-hospital support groups, an early and available intervention which promotes psychological integration of the birth experience and facilitates emotional as well as physical healing. There has been an attempt to address both the complexities of and the interrelationships among the various areas under discussion, and the importance of all such areas to the design and implementation processes. It will be demonstrated, in the following pages, that the program has, in addressing the health needs of a specific population, served to alleviate physiological and psychological distress; perhaps the implementation of similar programs will also lead to greater efficiency and efficacy of health care in the future.

REFERENCES

1. "Doctors Debate Surgery's Place in the Maternity Ward," New York Times, 24 March 1985.
2. "Rate of Hysterectomies Puzzles Experts," New York Times, 20 September 1988.
3. "NIH Consensus Development Task Force Statement on Cesarean Childbirth," American Journal of Obstetrics and Gynecology, 139 (April 15, 1981): 902-09.
4. Ann Oakley, "Social Consequences of Obstetric Technology: the Importance of Measuring 'Soft' Outcomes," Birth, 10 (Summer 1983): 99-108.
5. Jeanne Guillemin, "Babies by Cesarean: Who Chooses, Who Controls?" Hastings Center Report, 11 (June 1981): 15-18.
6. Ernst and Whinney, Accounting Firm, "Uses of DRGs By Medicare," New York, 1982 (Mimeographed).
7. Dyanne D. Affonso and Jaynelle F. Stichler, "Cesarean Birth: Women's Reactions," American Journal of Nursing, (March 1980): 468-470.
8. Lois Erb, Gail Hill, and Doreen Houston, "A Survey of Parents' Attitudes Toward Their Cesarean Births in Manitoba Hospitals," Birth, 10 (Summer 1983): 85-91.
9. Ramona T. Mercer, Kathryn C. Hackley, and Alan G. Bostrom, "Relationship of Psychosocial and Perinatal Variables to Perception of Childbirth," Nursing Research, 32 (July/August 1982): 202-07.
10. Joanne S. Marut and Ramona T. Mercer, "Comparison of Primiparas' Perceptions of Vaginal and Cesarean Birth," Nursing Research, 28 (Sept-Oct 1979): 260-266.
11. Mecca S. Cranley, Kathleen J. Hedahl, and Susan H. Pegg, "Women's Perceptions of Vaginal and Cesarean Deliveries," Nursing Research, 32 (Jan-Feb 1983): 10-15.
12. Joanne S. Marut, "The Special Needs of the Cesarean Mother," American Journal of Maternal Child Nursing, (July/August 1978): 202-06.
13. Elizabeth C. Shearer, "How do Parents Really Feel after Cesarean Birth?" Birth, 10:2 (Summer 1983).

14. Bonnie E. Cox and Elaine C. Smith, "The Mother's Self-Esteem After a Cesarean Delivery," American Journal of Maternal Child Nursing, 7 (September/October 1982): 309-14.
15. Kathy Higgins Berry, "The Body Image of a Primagravida Following Cesarean Delivery," Issues in Health Care of Women, 6: 367-76.
16. Karlene Davies, "A Conflict of Roles," Nursing Mirror, (July 7, 1982): iii-iv.
17. Cynthia S. Mutryn, "Psychosocial Impact of Cesarean Section on the Family: A Review of Recent Literature, Part II," ICEA News, 23 (February 1984): 4-5.
18. Kathleen J. Hedahl, "Cesarean Birth: A Real Family Affair," American Journal of Nursing, (March 1980): 471-2.
19. Juliene G. Lipson, "Cesarean Support Groups: Mutual Help and Education," Women and Health, 6 (Fall/Winter 1981): 27-39, and "Effects of a Support Group on the Emotional Impact of Cesarean Childbirth," Prevention in Human Services, 1: 17-29.
20. _____, and Virginia Peterson Tilden, "Psychological Integration of the Cesarean Birth Experience," American Journal of Orthopsychiatry, 50 (1980): 598-609.
21. Jacqueline Fawcett and Joyce C. Henklein, "Antenatal Education for Cesarean Birth: Extension of a Field Test," JOGNN, (January/February 1987): 61-65.
22. Camille B. Wortman, "Social Support and the Cancer Patient," Cancer, 53: 2239-2360.
23. Marc D. Schwartz, "Situation/Transition Groups: A Conceptualization and Review," American Journal of Orthopsychiatry, 45 (October 1975): 744-55. Similarly, see Leon H. Levy, "Processes and Activities in Groups," in Self-Help Groups for Coping With Crisis, ed. Morton A. Lieberman and Leonard D. Borman, San Francisco: Jossey-Bass, 1979, and Thomas J. Powell, "The Use of Self-Help Groups as Supportive Reference Communities," American Journal of Orthopsychiatry, 45 (October 1975): 756-64.
24. Helen Northen, "Social Work Groups in Health

Settings: Promises and Problems," Social Work in Health Care, 8 (Spring 1983): 107-121.

25. Michael Katch, "Commentary," Social Work in Health Care, 8 (Spring 1983): 121-124.

26. Abraham Lurie and Lawrence Shulman, "The Professional Connection with Self-Help Groups in Health Care Settings," Social Work in Health Care, 8 (Summer 1983): 69-77.

27. Marie A. Caputi, "A 'Quality of Life' Model for Social Work Practice in Health Care," Health and Social Work, 7 (May 1982): 103-10.

CHAPTER II

METHODOLOGY: PROGRAM DESIGN

INTRODUCTION.

The methodology of the project is described in this chapter. The chapter also reports the methods and findings of the needs assessment survey, and describes the implementation of those findings in the design of the support group program.

The nature of the research, the selection of a research design, the methods of monitoring and data collection, as well as the focus and structure of the program, are presented. The characteristics of the sample group, selection of a site for implementation of the program, and nature of the setting are explained.

Purpose of the Research

This project was originally undertaken as a quasi-experimental study, and later, due to unforeseen systemic factors on-site (see Implementation chapter, below), it was redesigned as an exploratory study. The project is in an area where published information about interventions by social workers is scanty. As discussed in the literature review, there have been some nursing studies that have reported on post-partum reactions of mothers to Cesarean surgery. Others have analyzed outpatient Cesarean support groups to provide information

about both the usefulness of such groups and the "trajectory of resolution" of the Cesarean process. However, no examination has been attempted of the utility of providing support while the mothers are in the earliest, most difficult stages: immediately after the birth of the child, while they are still in the hospital.

In this project, a program of post-partum support groups for mothers who had just delivered by Cesarean section was designed and implemented. The goal was to facilitate emotional and physical healing, and thus to decrease psychosocial morbidity, by providing a timely intervention.¹ As Lipson and Tilden² note, the initial postpartum period (which coincides with the hospital stay) is a time when strong emotions and efforts at physical coping are in the forefront. This is a period when the mother is often feeling overwhelmed, and when there is a high degree of sensitivity to the quality and amount of support provided.

The design of the support group program utilized data from a needs-assessment study conducted to investigate whether such a program was perceived as useful, and the group was offered with the intent of enhancing the mothers' ability to cope with the concomitant stresses of recuperation from surgery and demands of motherhood. The needs-assessment study will be discussed later in this chapter.

The purpose of the research was to test a model of intervention through the development, implementation and evaluation of a twice-weekly in-hospital support group program for Cesarean mothers. Whether and how such a program is perceived by the participants as contributing to the improvement of their mental and physical health, by facilitating coping with the physiological and psychological stresses of Cesarean delivery, was to be explored.

Originally, the mothers who participated in the support group program were to be compared with a "contrast group" of mothers who had not received the group intervention, so as to measure differences, if any, in mental and physical health outcomes and coping between the two groups. The contrast-group component of the program, including the use of standardized scales to discern differences between the mothers receiving the group intervention and the mothers with no intervention, had to be altered due to unforeseen systemic difficulties encountered during the contact and implementation stages. The focus of the study then became an exploration of the reactions of the Cesarean mothers to the group intervention, both immediately after the sessions and three months after delivery. A discussion of the reasons for the changes will be offered in the following chapter.

NEEDS ASSESSMENT STUDY

In order to explore whether social workers can assist Cesarean mothers in the integration of the birth experience within the health care setting by using an early, in-hospital intervention, as opposed to a post-discharge self-help support group, a study was conducted by the author in 1984. The purpose of the study was to obtain specific information about the needs of mothers who deliver by Cesarean section. The study sought to discern whether such mothers would consider post-partum support groups, which would combine professional services with peer support, to be helpful in integrating the psychological and physiological changes occurring during and after Cesarean delivery. It also asked Cesarean mothers to articulate their concerns, if any, about having different needs from mothers who delivered vaginally, by asking them about the level and degree of stress they had experienced during the Cesarean process, and about sources of support during this period.

Since this was a needs-assessment study, and since it is not possible to ask pregnant mothers about Cesarean support groups before they deliver, it was necessary to ask mothers who had already experienced Cesarean births, in retrospect, about supports they would have found helpful. An exploratory interview, including many open-ended questions, was thought to be a valuable tool in

gathering information as to the women's experiences, both physical and emotional, as well as their thoughts about sources of support.

The Survey Instrument and Sample

An existing interview guide, developed by Lipson and Tilden³ to determine the effects of post-discharge support groups on the psychological integration of the Cesarean experience, was revised extensively and adapted for the purposes of the study. The interviews (see Appendix I, Needs-Assessment Study Interview) included questions covering the following areas:

1. Background Data (questions 1-10)
2. Birth Plan and Preparation (questions 11-15)
3. Actual Birth Experience (questions 16-20)
4. Post-partum--Bonding (questions 21-23)
5. Coping Emotionally (questions 24-30)
6. Coping Physically (questions 31-34)
7. Support Systems/Interventions (questions 35-41)

An attempt was made to obtain interview subjects through a Cesarean support-group organization, but that proved impossible due to time constraints, difficulty in making direct contact with the organization and an apparent lack of support groups in this geographical area. Therefore, an accidental sample, consisting of ten women known to the investigator (and her network of friends and

colleagues) to have had both planned and unplanned Cesarean deliveries, was obtained.

Findings of the Survey

The three Hispanic and seven white mothers in the sample were an average of 28.1 years old at the time of delivery. The most recent birth had taken place nine months before the survey; the most distant Cesarean experience had occurred 21 years before. All of the mothers had expected to deliver vaginally, half by natural childbirth and half with planned anaesthesia. Very little, if any, information about Cesarean birth had been provided to the mothers before delivery: Only one mother had learned about Cesarean birth in a childbirth class; only two had received any information from their obstetricians; one had heard from a friend who had had a Cesarean delivery. The mothers had been given a variety of reasons for the necessity for Cesarean delivery: insufficient dilation of the cervix, cephalopelvic disproportion (where the infant's head was too large to fit through the pelvic opening), fetal distress (infant in danger of strangling or suffocating), transverse or breech position of infant, and placenta praevia.

Only one mother knew in advance that a Cesarean delivery would be necessary; the remainder were informed during labor, from a very few minutes to several hours before the actual surgery. The mother who knew in advance

felt disappointed; three mothers who were highly medicated or unconscious reported no reaction or higher priorities of concern ("I wasn't told. They gave me last rites. I was hemorrhaging and thought I was going to die."); the reactions of the other mothers ranged from relief, after long and difficult labor ("I was so tired--please do something....") to shock and distress ("I couldn't believe it. I fell apart."). Several of the mothers reported that they had experienced physical complications following delivery, including adhesions, infections, hepatitis, fever, cystitis, spinal headaches, hemorrhaging, and shock.

Questions about the immediate post-partum period included those assessing mother-infant bonding, as expressed by feelings about the baby, and opportunities to see, hold and feed the infant after birth. Feelings about the baby following surgery seemed to fall into two categories, excitement/eagerness/ecstasy ("Most gorgeous thing in the world...." "Thrilled...."), and detached/dead/distressed ("Tired. Couldn't think about him." "Thought he was dead." "Worried he wasn't normal."). Several mothers mentioned both types of feelings. Though a few mothers (4) saw their babies immediately after birth, the rest had to wait until one to three days after birth to even see their infants. None of the mothers was able to hold her baby until at least the day following

delivery, and some had to wait until up to four days after birth. Four mothers were able to feed their babies the day after delivery; the remainder waited two to six days, and three mothers who had planned to breast-feed were unable to do so due to complications following the surgery. However, despite these difficulties, and the mixture of feelings, most of the mothers did not express concern about their ability to mother their babies; the concerns that were mentioned had to do with being new mothers and having no experience with children, rather than with the Cesarean delivery per se.

The mothers were asked what their feelings were immediately after the Cesarean, while in the hospital, and in the first few weeks following delivery, in an attempt to assess emotional coping. Again, there were two modes of response immediately after the surgery: relieved/eager/excited ("Delighted...Baby was healthy, I was okay....") and cheated/depressed/shocked ("Missing something. Detached...." "Failure. Devastated. Sense of inadequacy--I didn't do it okay...."). Here, mothers expressed either one set of feelings or the other, rather than both, as above. While in hospital, a few felt good and enjoyed their visitors, but the majority were eager to get home, concerned about the baby, restless, and upset about not being like other new mothers. Once home, half felt all right emotionally, glad to be home with the baby;

the others felt depressed, nervous, scared, weak and worried. When presented with a checklist of selected feelings other Cesarean mothers had expressed during the first few weeks after delivery, many mothers in the sample chose more than one response: depression (6) and relief (6) were most often chosen, followed by anger, memory lapses, confusion, grief, and guilt.

When asked what help they had received in coping emotionally, half of the mothers said they had had no help at all. The remaining mothers mentioned family members (most often husband and mother), and/or their obstetrician, as sources of help; a fellow-patient who had had a Cesarean, and co-workers, were each mentioned by one mother.

When questioned about physical feelings after delivery, the mothers gave responses ranging from one mother's "Fine" to a variety of symptoms, including, for the majority, pain and exhaustion. Other physical reactions included weakness, nausea, gas pains, fever, and spinal headaches. When asked whether they had had any physical difficulties, half of the mothers said they had had problems, while in the hospital and/or after the return home, with weakness, pain, cystitis, severe gas pains, soreness, fatigue, trouble with urination and defecation, vision problems, and hepatitis mentioned specifically. Seven of the mothers said that they had had

no help of any kind in their attempts to cope with the healing process; the remaining three stated that they had been helped by nurses and/or doctors, who had given concrete instructions about walking to get rid of gas pains, to exercise, and/or to keep the incision clean.

When asked how they had felt about their bodies following the Cesarean experience, the responses ranged from one mother's "No different" to a variety of concerns, on the part of the other nine, about physical changes that had taken place and feelings about these changes: "I had a ruined abdomen. Can never wear a two-piece bathing suit. Every shred of dignity was taken away [during the surgical process]."

The mothers were asked in general about sources of support, and responded by listing husband, mother, other family members, and doctors, with some mothers reporting no sources of support during the entire Cesarean process. Most mothers said that the Cesarean experience had not affected their relationships with either their husbands or their babies, nor did they feel different from other mothers. The remainder mentioned feeling different, missing something by not having had vaginal birth. None of the mothers felt that having had a Cesarean had changed their view of parenthood.

The mothers were asked for suggestions that might be helpful to future mothers having Cesarean deliveries.

The mothers felt that information should be available during the prenatal, in-hospital and post-discharge periods. During the prenatal period, information should be available through childbirth classes, as well as from the obstetrician. Knowing about the Cesarean process beforehand was important so as to diminish the physical and emotional effects when it occurs: "It's a possibility everyone might face. It could be a reality--you need to be prepared."

Following delivery, while in the hospital, most mothers in the sample recommended a support group as a way to help new mothers cope with the Cesarean experience. It was felt that an opportunity to discuss experiences with peers as well as with professionals was important:

"....Information about what you can expect, physically and emotionally, and a chance to talk to somebody knowledgeable...." "....Maybe it would draw you away from your own preoccupations, and you could share feelings and help each other out."

A majority of the mothers felt that a support group would be helpful after discharge from the hospital, as the networking aspect, talking to others about what's going on, and the opportunity to get out of the home and help one another would be useful, especially for those who had no other sources of support or those who still felt traumatized by the Cesarean experience.

All of the mothers stated that if a support group had been available to them at the time of their Cesarean delivery, they would have participated. Many added that the groups should be available at more than one level (prenatal, in-hospital and/or post-discharge).

Implications of the Needs-Assessment Study for the Research Design

The factual data described above clearly depict a sample of mothers who were uninformed about Cesarean birth, had planned vaginal deliveries, and had little or no advance warning that a Cesarean delivery would take place. Their reactions to the emotional and physical stresses of Cesarean surgery, while affecting neither the bonding process with their infants nor their relationships with their partners or children, indicated that many had experienced distress during the recovery period, including emotional shock, depression, anger, confusion and concern about their babies' well-being, and physical pain, exhaustion, and various types of discomfort. While some mothers reported receiving information and/or support to help them through this stressful time, many mothers reported receiving neither. Support groups, especially those occurring during the immediate post-partum period, were seen by all the mothers as an important way of facilitating the coping process. Further, the mothers in the study sample indicated that such groups should include

both information (from professionals) and peer support (from other Cesarean mothers).

In addition to the issues discussed above, there appeared to be links between several factors discussed below and how well the mothers coped emotionally with the Cesarean experience. Examining these links permitted the investigator to draw inferences which proved helpful in designing the content of the support-group intervention.

A particular constellation of responses was associated with answers to the question, "What was the reason for your having a Cesarean?" Some of the mothers answered this question by referring to problems of the baby (strangling in umbilical cord, transverse position, etc.), while others indicated problems they themselves had experienced (irregular labor, small pelvis, etc.). The "baby-problem" group had a different profile on answers to questions about bonding, emotional coping and physical reactions than did the "mother-problem" group. The investigator inferred, from their responses, that mothers who defined the reason for their having a Cesarean in terms of a problem their baby was experiencing perceived the experience initially as more painful and exhausting, and felt more cheated and depressed at first, than mothers who defined the Cesarean in terms of their own physical problems. The "baby-problem" group also responded with 1) more eager/excited feelings, and 2) fewer concerns about

mothering the baby, and expressed 3) more positive feelings once they returned home from the hospital and 4) less need for a post-discharge support group, than the "mother-problem" group. This led to consideration of including more specific material on "baby-problem" issues in the group protocol, as well as of providing reassurance that Cesarean surgery was not the mother's (or anybody's) "fault", but was performed in order to insure the best possible outcome for both mother and infant.

In looking at the possible connection between receiving information/support around the Cesarean delivery, and the coping process, it was discovered that those mothers in the study sample who indicated that they had received such information and support also reported that they had 1) minimal trouble with their feelings while in the hospital, 2) no concerns about their ability to mother their babies, 3) felt good and did not have trouble adjusting upon returning home (with no reports of depression, weakness, etc.), and 4) a feeling of relief during the first weeks after the delivery process. Though it was not possible to tease out which factor or combination of factors may have influenced this set of possible indicators of good emotional coping responses, it was hoped that the factors (information and support) could be examined with the population involved in the actual support group program and would support the hypothesis

that the mothers who received the support group intervention would report better emotional coping than those in the proposed "contrast" group.

Finally, the responses of the mothers who reported receiving help in order to cope with the emotional aspects of the Cesarean experience (half of the study sample) were compared with the responses of those mothers who reported no help, in regard to the question, "Which term(s) describe most accurately your feelings during the first weeks following delivery? a. depression, b. anger, c. grief, d. guilt, e. confusion, f. memory lapses, g. relief, h. other." For the purposes of this analysis, responses "a" through "f" were characterized as evidence of emotional distress, while response "g" was felt to be neutral. The "help-receiving" group checked less than half as many emotional-distress responses as the "no-help" group. Though the numbers in this needs-assessment study were too small for any definite statements to be made, it seemed clear that the mothers who reported receiving help in coping emotionally (which might be another way of defining support) indicated far fewer feelings of distress than those who did not receive such help.

SELECTION AND DESCRIPTION OF SITE FOR IMPLEMENTATION

The investigator was employed, at the time of the research, in a medium-sized voluntary hospital operated under the auspices of a religious organization. Although consideration was given to conducting the support group program at that hospital, several factors mitigated against doing so. For example, the investigator was a social worker in the outpatient mental health service, rather than in health care, and her personal network of inpatient hospital social work connections was relatively small. Further, relations between the administrations of Psychiatry (where the investigator was located) and Social Work (which covered the rest of the hospital's departments) were, at best, distant. Consequently, when the investigator was invited to conduct the support group program at "East Side Medical Center" (a fictitious name) by the Assistant Director of Social Work there, a personal friend who was interested in getting her department involved in research efforts and was eager to test out the idea of a new social work intervention for Cesarean mothers, it seemed wise to accept the offer.

"East Side Medical Center" is a large (690 beds), voluntary hospital located in a prestigious neighborhood in New York City. The hospital is affiliated with a medical school, but is not a major teaching hospital. Although East Side Medical Center draws its clientele from

the entire metropolitan area, and has a sizeable clinic population, many of the patients reside in the immediate neighborhood.

The Social Work department consists of 23 M.S.W. social workers, including the Director and two Assistant Directors, 6 social work students, and 7 clerical staff. The Department provides counseling services to patients and families to deal with the impact of illness, as well as discharge planning to assist patients with aftercare; offers information about entitlements; and provides education, as well as written material, to individual patients and groups of patients. At the time the support group program was conducted, the social worker assigned to Obstetrics covered both Inpatient and Clinic services, spending approximately 4/5 of her time in the Clinic. She had a large, active caseload, given the more than 3000 deliveries per year performed at the hospital. The only component of Obstetrics not covered by the OB social worker was the Neonatal Critical Care Unit, covered by a different worker, who conducted a regular group for parents of infants on the unit, co-led with a nurse and a psychiatrist. No other social work groups existed on Obstetrics. The only group activities in the Post-Partum unit were classes on breast-feeding and infant care, taught by staff nurses.

The support group sessions took place on the

Post-Partum unit of the Obstetrics and Gynecology floor. Other units on this floor included Labor and Delivery, Newborn Nursery and Gynecology. The Post-Partum unit consisted of 18 rooms, of which three were private and the rest semi-private. (On occasion, overflow Obstetrical patients were assigned to rooms on the Gynecology wing; when Cesarean patients were assigned there, which happened infrequently, the investigator invited them to participate in the support groups, but few availed themselves of the opportunity due to the considerable distance between the two units.)

The Post-Partum unit is L-shaped, with the Nurses' Station located at the corner of the L. The halls were adequately, if somewhat dimly, lit, and the patient rooms were more spacious than in many other hospitals. Other than in the private rooms, patients were assigned to beds without regard to Clinic or "paying" status. The Nurses' Station was cramped and often overcrowded, but no more so than in most hospitals. The Lounge, a small room opposite the Nurses' Station, was the location for all classes on the unit and was the only available setting for the support group meetings. It was accessible from all rooms, and could accommodate--tightly--both the group participants and their babies' wheeled isolettes, if the mothers chose to bring their infants. Noise from the Nurses' Station, as well as from housekeeping and

maintenance personnel, often was disruptive to the group sessions. From time to time, the room was not clean, or was permeated with smoke from previous inhabitants. On one occasion, the rug in the room was being cleaned by the maintenance staff, and the group session had to be cancelled for lack of an alternate location.

The Post-Partum unit was headed by the Patient Care Coordinator (PCC), a quiet, conscientious, serious and experienced nurse, and was usually staffed, on the day shift, by 5 or 6 nurses. These nurses, perhaps reflecting the choice of the PCC, were young, and most were either unmarried or, if married, did not have children.

The nurses rotated between Post-Partum and Nursery, and also rotated in terms of which district, or section of the unit, they were assigned to each day. The Nurse Educator for Maternal/Child Health, who was responsible for the prenatal classes, as well as for training the childbirth educators, occasionally had business on the unit as well. Aides, housekeepers and unit clerk completed the unit personnel. A volunteer was present part-time, and a graduate student in nursing was also in attendance part of the week.

The general tone of the unit was competent, quiet and low-keyed, despite the fact that the beds were usually filled to capacity. In 1987, the year in which the support group program was conducted, there were 3766

deliveries at East Side, of which 1069, or 28%, were by Cesarean section. The average length of stay for Cesarean mothers in 1987 was 6.1 days.

SELECTION OF THE SAMPLE

The target population for the study consisted of mothers who delivered by Cesarean section at East Side Medical Center during the period immediately preceding, and including, the time when the support groups were being offered. The "contrast group" mothers were to be recruited before the support group program was implemented, in order to avoid the problem involved in offering service to one group, but not to another, during the same time period.

The mothers who were to be considered for participation in the support group program were to consist of all mothers at East Side delivering by Cesarean, during the six- to eight-week period when the support groups were being offered. The plan was to obtain a "contrast group" of at least 25 mothers, and a group of 25 to 50 support-group participants as well, in order to obtain a sample large enough to yield statistical significance. All Cesarean mothers two days or more post-partum were to be included, with the exception of a small number of mothers with infants in the Neonatal Critical Care Unit (NCCU), in order to involve a sufficient number of mothers

within the time-frame available to the investigator.

Mothers with infants in NCCU were excluded from the sample because they were already targeted for individual social work intervention as well as a parents' group. Because of their babies' critical health status, it was thought that they would be likely to be concentrating on concerns around the infants, and might draw the support group's focus away from concerns around the mothers' own physical and emotional issues. Furthermore, they were already receiving social work attention, while the general population of Cesarean mothers was not.

The plan was to invite each mother to participate in the support group, and to obtain informed consent from each participant, as well as permission to contact her by telephone a few weeks after discharge. If she were willing to cooperate at that time, the follow-up interview would take place by phone.

The anticipated limitations in the selection process had to do with possible reluctance to participate in the groups on the part of some mothers related to socio-cultural values; with physical discomfort preventing participation; or with insufficient command of English preventing or inhibiting participation. None of these problems, however, prevented the recruitment of a sufficient number of participants. (In fact, relatively

few of the mothers who did not participate seemed to do so out of social/cultural reluctance or language barriers. A number of mothers were unable to come to the group sessions due to physical discomfort. This aspect of the selection process will be discussed further in the Findings chapter.)

DEFINITION OF KEY VARIABLES

The support group program was designed to provide social support to mothers who had just delivered by Cesarean section, in order to facilitate the mothers' coping ability during a period of crisis⁴ and thus improve mental and physical health outcomes. The groups would be short-term in nature and would take place within a health-care setting.

The definition, role and effectiveness of social support are among the most heavily debated issues in recent health research literature. For the purposes of this study, social support was defined as consisting of instrumental, educational and emotional factors, provided through social interactions and relationships with others.⁵

Mental health outcomes were defined as the number and type of self-reported symptoms and sensations listed during the follow-up interview, including perceived anxiety, guilt, helplessness-hopelessness, self-esteem,

and sadness.

Similarly, physical health outcomes were the number and type of self-reported symptoms and sensations listed during a post-discharge follow-up interview.

Coping was defined as the complex of psychological resources and specific responses and mechanisms used by an individual to deal with stressful incidents and processes.

Participation in short-term groups in health care settings was defined specifically as attending one or more meetings of an in-hospital Cesarean support group.

THE CESAREAN SUPPORT GROUP PROGRAM

The support group meetings were to be held twice weekly for a period of eight weeks, and were to be approximately 45 minutes in duration. The frequency would allow mothers the possibility of attending more than one session during their hospital stay, and the relatively short length of the sessions was predicated on the assumption (supported by the experience of the investigator and of others) that individuals who had just undergone abdominal surgery would be experiencing a good deal of physical discomfort, and would not be able to sit still for more than 30-45 minutes at most.

The groups were to be co-led by the investigator and a nurse, to allow for maximum

informational/educational input by both professionals regarding the physical and emotional issues of Cesarean delivery. The content was to include material on the surgical process itself, the physical sequelae of Cesarean surgery and information about physical self-care, the emotional sequelae and information about ways of obtaining concrete and emotional support, and the facilitation of peer support among participants by encouraging them to share their experiences and concerns. Outline I is a copy of the group protocol.

OUTLINE I

PROTOCOL FOR SUPPORT GROUP SESSIONS

1. Introduction of group leader (and nurse co-leader, if available), and statement of purpose of group.

a. Having a baby by Cesarean can be somewhat different than by vaginal delivery, and you may want to know more about what happened and why, what to expect, what to do, etc.

b. Maybe you've been told about learning how to feed, bathe, and take care of your baby, but you might also have some questions as to how you feel physically, and also some feelings about the Cesarean.

2. Ask group members to introduce themselves [when did they deliver?], and to state any concerns they might have, to start off. They will probably get into the issue of anaesthesia, as well as feelings of surprise, worry, etc. as to why the Cesarean was necessary. List the concerns: physical, emotional, other.

3. If group is reticent about starting off with their own concerns, ask if anyone knows someone who had a Cesarean, what their concerns were, and how they coped with these concerns. The concerns will likely include immediate postpartum issues--is the baby all right, pain, the IV, the catheter, what it was like getting out of bed for the first time, coughing, etc.

4. Identify the concerns as being issues that are common

among them and among most Cesarean mothers that have been asked to state their concerns.

a. Ask how they're dealing with physical issues. Ongoing issues: gas pains (what causes them? why can't solid foods be eaten at first?), the incision (and the common fantasy that if you cough it will pop open!).

b. Invite the nurse (if one is co-leading) to respond to the physical issues--OR have brief general discussion--explain about cutting through the different layers and sewing each one up separately. Discuss staples and stitches and showers; reassure that removing sutures or staples is not painful, and that they will be taken out before discharge. Mention about excessive perspiration and urination and swelling of hands and feet as being due to retention of fluids. Then refer mothers to their primary care nurse and OB for further discussion if concerns continue.

c. How to hasten the healing process--walking, avoiding lifting (have baby brought to them!), splinting abdomen with hands or pillow; using pillow on lap while feeding baby; etc.

5. List of emotional issues (including the whole list even if they haven't enumerated all at first): anxious, sad, guilty, relieved, how's my body going to look, what about sex--will my partner still want me, will I ever feel sexual again, will I be able to bond with my baby, don't

feel up to taking care of baby physically and/or emotionally, didn't do it "right" re delivery, etc.

a. Emphasize that these are understandable and/or appropriate feelings under the circumstances. This is an important and meaningful time and most of you weren't expecting this outcome.

b. Address and correct misperceptions.

c. Look at whether they feel they have sources of emotional support available; identify possibilities (partner, family, friends, professionals, etc.)

d. Discuss how they may be able to mobilize support (let people know this is major surgery as well as childbirth!).

e. Point out limitations of physical activity (no laundry, grocery bags, etc.) at first--who will be around to help at home? Importance of allowing body to heal.

6. Facilitate discussion between group members--they can be supportive to one another while in hospital, and share concerns. Ask if there are additional questions.

7. Leave them with a summary (and handout, if possible) of what's been discussed and someone they can contact if they need to talk more about these issues.

Participants for each group session were to be recruited from among the mothers on the Post-Partum unit on the days the sessions were held. Mothers who were more than 2 days post-partum, who did not have an infant in the NCCU, and who were not being discharged on that day, were to be invited to the group by the investigator, who would obtain information about these factors from the nursing staff and unit Kardex file beforehand.

DATA COLLECTION, MONITORING DEVICES, EVALUATION INSTRUMENTS

A number of sources of information about the mothers and about the group sessions were to be utilized in the data collection process. The medical records and the unit Kardex file provided information about the mothers' ages, occupations, marital status, and residence, as well as whether or not they were Clinic patients. These sources also yielded information as to the reason for Cesarean, date of delivery, and room number. The investigator utilized these sources, first, when recruiting members for the contrast group, and later, when selecting mothers to invite to the support group sessions. Some of the descriptive data from the Kardex file and medical records were also utilized in analyzing the characteristics of the support group participants.

Feedback Form

It was suggested that support group participants be asked to evaluate the group content, and that this be done by means of a post-group evaluation.

After each group session, the investigator was to approach each mother individually and fill out the form with her. The following areas were covered: What happened in the group? What helped? What would they suggest? "Satisfaction" issues were to be explored by means of this evaluation, and information might be forthcoming as to the problems/key issues as perceived by the participants. Further, the evaluation form would provide guidelines for revision of the group content, if necessary, as well as possible information about the group process. A post-group Feedback Form was devised (see Appendix II), adapted from a study by Davidson.⁶

Follow-up Questionnaire

Approximately six to eight weeks post-partum, each mother in both the contrast group and the support group program was to be interviewed by telephone in order to elicit information about mental and physical health outcomes and coping. (The telephone interview, as a data collection tool, has been found to yield data of good quality, to maximize response rate, and to be cost-effective.⁷ Further, expecting mothers of

two-month-old infants to be available for an in-person interview would be highly unrealistic.) The interview guide (see Appendix III) was adapted from the questionnaire used in the needs-assessment study, and included both structured and open-ended questions about the following:

1. Background Information
2. Birth Plan and Preparation
3. Actual Birth Experience
4. Bonding
5. Coping Physically
6. Coping Emotionally
7. Perceptions Regarding Help
8. Support Systems
9. Suggestions for the Future
10. Cesarean Group Experience

REFERENCES

1. Joanne S. Marut, "The Special Needs of the Cesarean Mother," American Journal of Maternal Child Nursing, (July/August 1978): 202-06.
2. Juliene G. Lipson and Virginia Peterson Tilden, "Psychological Integration of the Cesarean Birth Experience," American Journal of Orthopsychiatry, 50 (1980): 598-609.
3. Ibid.
4. For a revision of the conventional concept of crisis, see Rosemary C. Lukton, "Myths and Realities of Crisis Intervention," Social Casework, 63:2 (1982). Psychoeducational approaches to dealing with crisis situations have been utilized recently, primarily by family therapists. A representative 'crisis-oriented' model includes the following objectives: (1) identifying the two or three current, most hazardous stressors; (2) developing strategies to prevent and cope with stress; (3) implementing, evaluating and refining the strategies; (4) utilizing anticipatory planning to cope with and prevent future stresses. This model is to be found in Hal S. Kopeikin, Valerie Marshall and Michael J. Goldstein, "Stages and Impact of Crisis-Oriented Family Therapy in the Aftercare of Acute Schizophrenia," Family Therapy in Schizophrenia, ed. William R. McFarlane, New York: Guilford Press, 1983. Similar models are to be found in William R. McFarlane, C. Christian Beels and Stephen Rosenheck, "New Developments in the Family Treatment of the Psychotic Disorders," Psychiatry Update, ed. Lester Grinspoon, Washington, D.C.: American Psychiatric Press, 1983, and Carol M. Anderson, Gerard E. Hogarty, and Douglass J. Reiss, "Family Treatment of Adult Schizophrenic Patients: A Psycho-Educational Approach," Schizophrenia Bulletin, 6: 3 (1980).
5. For a more thorough discussion of support, see Judith C. Nelsen, "Support: A Necessary Condition for Change," Social Work, September 1980: 388-92.
6. Kay W. Davidson, "Development of a Support Program for Social Workers Serving Cancer Patients," (D.S.W. dissertation, City University of New York, 1983).
7. Jane E. Tausig and Ellen W. Freeman, "The Next Best Thing to Being There: Conducting the Clinical Research Interview by Telephone," American Journal of

Orthopsychiatry, 58: 3 (July 1988), 418-27.

CHAPTER III

IMPLEMENTATION OF THE PROGRAM: ISSUES AND CONSEQUENCES

INTRODUCTION

As described in the previous chapter, the original research design of the Cesarean Support Group project included the provision of support groups for mothers who had just undergone Cesarean deliveries. Follow-up interviews were to be conducted at six to eight weeks post-partum both with these mothers and with a contrast group of mothers who had not participated in the support groups. The intervention group and the contrast group were to be compared using standardized instruments measuring relative degrees of depression, self-esteem, and self- and body-image. All of the mothers were also to be interviewed by means of a telephone questionnaire which asked about their birth plan and preparation, actual birth experience, the mother-infant bonding process, physical and emotional coping, and experience of support. The study was to be conducted at a sizeable urban voluntary hospital.

The group sessions, as well as the follow-up interviews of the two groups of mothers, were to be executed according to a timetable. The original plan called for the recruitment of contrast group mothers to take place first, followed by a two-month period of

support-group sessions, and for the follow-up interviews to take place within six to eight weeks after each mother's date of delivery. The original target date for beginning the support groups was September, 1986, and the anticipated time-frame for the entire project was five months. During the course of the initiation, contact and implementation stages of the project, it became necessary to modify both design and timetable.

Institutional Context

The study was conducted in a setting (see previous chapter for "Description of Setting") to which the author was a stranger--an outsider--who had been invited to conduct the project by the Assistant Director of Social Work for Quality Assurance, Education and Programming. Since research is highly valued in the hospital, and since the Department of Social Work had not conducted any formal research projects prior to this study, both the Director and the Assistant Director of Social Work expressed eagerness to have the study located in their department.

The hospital is a large, complex, multidisciplined institution with strong elements of hierarchical structure, as well as a good deal of autonomy between various components. Though hospitals such as this one, affiliated with medical schools, often have many joint research projects and interprofessional collaborative relationships, there was little evidence of formal and

informal interprofessional collaboration between nurses, doctors and social workers on the unit during the time when the project was executed. The Social Work Department is relatively small and, like many social service units in "host" institutions such as hospitals, schools, etc., "must contend with members of other professions who have little understanding of social services".¹ As a non-staff person who was attempting to implement a pilot project, the investigator's position within the organization was marginal at best. These factors were, perhaps, not unusual, given the nature of the institution, but they were to have reverberations that were not immediately apparent, in terms of the implementation of the project.

Program Legitimation Process

In order to conduct the study, the author's proposed design had to be approved by both the Department of Obstetrics and Gynecology and the Department of Nursing, prior to submission to the hospital's Research Advisory Committee (RAC) and approval by its Medical Board. The proposal was submitted in January, 1986, approved by OB-GYN in April and by Nursing in June. This part of the process took 9 months, partly because the RAC did not meet during the summer and partly due to a delay--for unspecified reasons--by Nursing. Apparently, there was some concern that the post-Cesarean support groups, to be

held on the premises of the Post-Partum unit, might be more the province of Nursing than of Social Work. The issue of departmental power, which can be increased by preventing other units from providing certain services and by using strategies to maintain territorial boundaries vis-a-vis other departments, is an important one in hospitals, and "East Side Medical Center" is no exception.²

The RAC, which met to discuss the project in September, 1986, included representatives from various components of the hospital--medicine, nursing, administration, etc.--as well as outside "experts". Both the Director and the Assistant Director of Social Work attended this meeting and spoke in favor of the project. Some questions were raised as to the format of the group sessions, and in response to these concerns the investigator developed a detailed group protocol (see previous chapter). It was understood that, of necessity, there would be flexibility within the structure and process of each of the group sessions. After approval was given by the RAC, a pro forma approval was given by the Medical Board in late October, 1986.

ALTERATIONS IN PROGRAM DESIGN: SYSTEMIC FACTORS

Initiation Stage

The final step in the rather lengthy approval process was to be discussion of the project by the hospital's Legal Services Department, so that an Informed Consent form that was acceptable to Legal Services could be developed. This form would be signed by each mother participating in the study. It was expected that the form would be approved shortly after approval by the RAC. However, it was not until the beginning of November that a sample "Informed Consent" form was provided to the investigator by Legal Services. An informed consent form to be used for the study participants was devised to meet the requirements of the Legal Services Department and was submitted to Legal Services in early November.

Because of the lengthy period of negotiations for approval by the various departments of the administration, the contrast group recruitment had to be delayed. The members of the contrast group were to be recruited while still in the hospital, but in order that no mothers be denied access to the support group service when it actually took place, the recruitment for the contrast group had to be done before the support group program was to go into effect. Recruitment was put on "hold", but the expectation was still that the consent form would be approved, and the contrast group mothers' written

permission could then be secured, while they were still in the hospital.

By mid-November, it was felt that any further delay in becoming oriented to the Post-Partum Unit, via the social work staff member who was assigned to both Inpatient and Outpatient Obstetrics (the OB social worker), would push the timetable back even more. There was still no word from Legal Services during this time, despite numerous phone calls from the Social Work Assistant Director.

In early December, the investigator met with the OB social worker for a brief tour of the Post-Partum, Labor and Delivery, and Nursery units. The OB social worker was somewhat pessimistic as to the success of the Cesarean support group project, though she expressed support verbally. She explained that, due to her heavy work load, she spent most of her time in the Clinic; however, she offered to sit in on a group session so that she could become more aware of the investigator's work. In addition to the tour of the OB components, the social worker introduced the investigator at a meeting of the Nursing Education staff so that the investigator could meet the Director of Maternal-Child Health Nursing, and the project was discussed with the Nursing Education staff. An appointment was made to meet with the Patient Care Coordinator (PCC, or Head Nurse) of the Post-Partum

unit, where the support group sessions were to be held.

The meeting with the Post-Partum unit PCC also included the Nurse Educator for Maternal-Child Health. The project was discussed, and the participation of a nurse as co-leader of the support groups was proposed.³ The Nurse Educator volunteered for this post, with the tacit approval of the PCC, and a tentative time schedule, where support group meetings would not interfere with other activities on the unit, was adopted. However, another delay in implementation occurred at this point: the PCC was firm about the fact that staff shortages, due to holiday vacations around Christmas and New Year's, would preclude starting the group sessions until after January 1.

It is to be noted that, although approval for the Cesarean Support Group study was received from the upper levels of the hospital hierarchy,⁴ in no way was "approval"--or cooperation--assured at the unit staff/line worker level. There, the program may have been experienced as being imposed on the staff nurses and PCC (not to mention the OB social worker), despite the fact that it meant no extra work for any of them. Consequently, one task of the investigator was to "win over" the unit staff, PCC and OB social worker, so as to facilitate implementation of the program⁵. To do this, information about how the Post-Partum unit operated,

and about its perceived systemic needs, had to be taken into account. Therefore, it would have been a mistake to argue with the PCC about when to begin the groups. To insist on giving an in-service lecture about the support group program to the staff nurses, after hearing from the PCC that there was no time, even under normal circumstances, for staff meetings, would have been equally ill-advised. Consequently, the target date for the commencement of the support groups had to be delayed again, and the investigator would have to educate each staff nurse about the program individually.⁶

The Nurse Educator volunteered to co-lead the support groups. This was at first experienced negatively, by the investigator, as being "imposed" by the PCC. However, it turned out to be a blessing, albeit a mixed one. The Nurse Educator's expertise in the areas of the Cesarean surgical procedures and physical healing process, and her experience in teaching prenatal classes (and prenatal educators), as well as her breezy, warm manner, complemented the investigator's knowledge of the psychological issues of Cesarean delivery and her somewhat more reserved style. However, the Nurse Educator's flexible schedule and freedom to choose her own tasks were perceived, by many of the hardworking and often overstressed unit staff nurses, as well as by the OB social worker and others in the hospital, as laziness and

lack of responsibility.⁷

Recruitment

Recruitment of the contrast group was begun immediately following the investigator's brief orientation to the Post-Partum unit. For a short while, the investigator followed one of the staff nurses as she carried out her usual patient care tasks.⁸ In addition, the investigator spent a good deal of time at the nurses' station, reading medical charts in order to obtain information about Cesarean mothers. This facilitated getting to know the nurses, unit clerk, volunteer, nursing student, and other personnel who served or came in contact with the unit. After getting a "feel" for the physical setup and the degree of access to patients on the unit, the investigator began to identify the mothers who had delivered by Cesarean, at first from the lists each nurse carried, and subsequently from the unit Kardex file. [The Kardex contained such information as patient's name, room number, method of delivery, and, usually, reason for Cesarean, if performed. The Kardex was also supposed to inform staff as to whether the infant was in the Neonatal Critical Care Unit. This information was often missing, and so a number of mothers with infants in NCCU were inadvertently recruited for the contrast group or, later, invited to the support group sessions. A number of these mothers did attend the groups, and their

feedback was not substantially different from that of the other mothers.] Each Cesarean mother was approached by the investigator and was told that the investigator was trying to find out how the hospital could help Cesarean mothers better. Each was then asked whether the investigator could phone in a few weeks and ask some questions about the Cesarean experience. Those mothers who agreed to be interviewed gave their phone numbers to the investigator and were told that a consent form would be mailed to them shortly, with the expectation that an approved consent form would be ready in a few days.

By the end of December, the investigator had spent a considerable amount of time on the Post-Partum unit. Twenty-six mothers had given verbal permission to be interviewed. However, the fact that Legal Services did not approve the consent form in a timely manner was to alter the research design in a major fashion: when the Informed Consent forms were mailed out to the contrast group mothers, who had already given verbal permission for the follow-up interviews, only 8 of the 26 mothers returned the forms. At this point, after consultation with the Dissertation Committee as to whether to send another round of forms, make telephone calls, or use some other method to get in touch with the contrast group mothers, it was recommended that the contrast group be dropped, and that the study be reformulated as a

descriptive one. The mothers who participated in the support groups would be asked for immediate feedback after each group session, and a follow-up interview would take place approximately two months after discharge. The standardized measurements of depression, self-esteem, etc. would be deleted, as there was now to be no comparison group.

In order to get a better idea of the educational/support opportunities already offered on the unit, the investigator attended a breast-feeding class, which consisted of a slide presentation and a lecture by a staff nurse, with very little input from, or interaction among, the mothers attending the session. The investigator also used this period of time to become acclimated to the routine and "flow" of the unit, to meet the staff nurses, and to describe the support group program to each nurse on the day shift, many of whom expressed interest in co-leading the groups if the Nurse Educator were not to be available.

Legal Services had not yet given approval for the consent form, and the support groups were scheduled to start January 6. Approval was finally forthcoming on January 2, after more insistent phone calls from the Assistant Director of Social Work. Thus, the implementation phase was begun, finally, several months after the original target date. The long delays in the

many-tiered approval process did not substantially affect the support group component of the study.

Implementation Stage

The support group sessions were begun in January, 1987, one year after the Cesarean Support Group proposal had been submitted to the hospital. The following format for recruiting group members quickly evolved: About one and one-half hours before each group session, the investigator reviewed the unit Kardex file with the assistance of some of the staff nurses. Mothers who had had Cesareans were selected, ruling out those who had delivered within the previous two days (because their physical discomfort would preclude attendance) and those who were being discharged that day (because they were too preoccupied with preparing themselves and their infants for departure). The remaining mothers were contacted individually in their rooms. A brief explanation of the group was offered. Each mother was invited to attend, and to bring her baby if she so desired. About five minutes before each session, the investigator again visited each mother and reminded her that the group would be beginning shortly.

The sessions were held three times a week for the month of January, twice a week in February, and one time in early March, for a total of 18 sessions. The decrease in frequency was caused by the fact that the investigator

had to return to her job from a leave of absence which she originally took in order to do the study. Because of the delays in implementing the support groups, it was necessary to continue past the expected date of termination of the support groups.

The group sessions were approximately 45 minutes in duration, and were held in the late morning, a time when the mothers were not involved in other activities such as meals, visits from doctors, patient care by nursing staff, infant care, or receiving visitors. The groups met in the lounge, a rather small room centrally located on the unit, across from the Nurse's Station. The room had several uncomfortable chairs and was rather poorly lit, but was used for all the classes (breast-feeding, infant care, and pre-discharge) already being held on the unit, and was the only possible location for the group sessions that met the requirements of availability and accessibility. It was necessary, on occasion, to ask other inhabitants of the lounge--staff nurses taking a break, an occasional non-Cesarean mother, maintenance staff, visitors--to leave, before the group sessions could begin. There were a few times when extra chairs had to be secured from the nurses' station, some occasions when smokers had left the atmosphere uncondusive to breathing, tight squeezes when the group was large or when a number of mothers wheeled their babies' isolettes

into the room, and one incident when the hospital's carpet-cleaning schedule coincided with the time scheduled for the group session. (On this last occasion, by some fortunate coincidence, it turned out that no mothers chose to attend the group, or the session might have been held in the corridor...)

Although the groups were originally planned to begin at 10:30 a.m., when the PCC had said that the mothers were free, the investigator found, after scheduling the first two meetings for that hour, that many mothers were still busy feeding their infants. Subsequent meetings were scheduled for 11:00--a tight squeeze, because lunch and visiting hours both occurred at noon.

The first "group" actually consisted of only one mother, out of eight mothers on the unit with Cesarean deliveries; the investigator was to learn, despite careful planning and screening, that merely being eligible for the group, and/or expressing willingness to come, did not guarantee attendance: besides infant care, telephone calls, visits from physicians and other unforeseen interruptions, some mothers found themselves too tired, or in too much pain, when the time for the group meeting arrived.

After the first session, one of the staff nurses suggested that mothers who were two days post-partum be invited to attend; the investigator had thought to rule

them out because of possible pain, complications pursuant to being connected to IV poles, and difficulty ambulating. The nurses felt that some mothers might want to attend despite these difficulties, and they were proven correct. Changing the time of the sessions, as well as the parameters for attendance, the days the group was offered, and the way in which the investigator invited the mothers to attend (mentioning that the group for Cesarean mothers was something new being offered rather than tried) all seemed to affect attendance positively, though some sessions had few participants and two sessions were cancelled due to non-attendance. It became clear that the mothers needed about an hour and a half between being informed of/invited to the sessions and the time the groups actually occurred. They moved slowly and with discomfort, and such activities as feeding their infants, taking showers, even putting on a bathrobe, consumed a great deal of time and energy, with everything needing to be planned in advance so as to minimize pain and exhaustion.

There was a good deal of flexibility in how the material in the group protocol (see preceding chapter) was presented and dealt with, since the group was meant to be a source of support as well as a means of receiving information. Consequently, after introductions of leaders and participants had occurred, the mothers were invited to

tell their stories and voice their concerns, and the education/information content was interwoven with the actual material supplied by the mothers. Since each group session was an entity, no mother attended more than one session, and the groups varied in number of participants, each meeting had its own flavor, though both co-leaders were careful to insure that each session contained essential information about the physical and emotional sequelae of Cesarean birth, and about the importance of obtaining both concrete and emotional support in order to facilitate the healing process.

After the first few sessions, the staff nurses began to encourage the mothers to attend the support group. In addition, the PCC consented to post typewritten notices of the meetings in the patient rooms, though the notices themselves were small and inconspicuous.⁹ By the sixth session, one staff nurse willingly co-led the group when the Nurse Educator was unable to attend, and subsequently volunteered to co-lead another session. At the end of January, when it became clear that the sessions would have to be decreased to twice a week because of the investigator's work schedule, the future of the group--that is, the issue of continuing it beyond the research period--was discussed with both the PCC and the Assistant Director of Social Work. The issue of a successor to the investigator was raised, but not

settled, at this point in time. The PCC commented that she thought the group was very useful, especially in helping the patients to "ventilate" about the Cesarean process. The Nurse Educator and the investigator discussed revising the existing written handout on Cesarean birth in light of the issues raised in the group, with more content on the emotional sequelae of Cesarean delivery, suggestions for physical healing and physical and emotional support, etc. Thus, by the midpoint of the investigator's time on the Post-Partum unit, good relationships had been established with the staff nurses, the PCC, and the Nurse Educator.

During the two-month period when the investigator was conducting the support group sessions, a number of non-participants were permitted to observe the proceedings. These included, at one time or another, staff nurses, the PCC, a member of the hospital's Public Relations office, the OB Social Worker, a social work student, a graduate student nurse, a private-duty nurse of one of the participating mothers, a husband, and a mother. Though most of these non-participants observed in silence, and most commented afterwards that the group was a good idea, there was one incident where the interaction of a participant with her somewhat intrusive mother disrupted the group process. This led to a re-thinking of the policy on observers, especially when reinforced by some of

the mothers' feedback, and to a dilemma of sorts: in order to institutionalize the program, it was necessary to demonstrate to staff and administration that the groups were useful, helpful, and successful, but at the same time, commitment to client service meant keeping the focus on the participants' needs, rather than on the needs of investigator, staff or family members. It was felt that, if the program were to continue after the investigator had finished the study, some policy should be set as to attendance of non-participants, with the thought that an occasional staff observer (especially students, trainees or staff who might co-lead the group at a later date), or an occasional partner (who might benefit from hearing how important support would be to his partner's recovery) might attend, with the consent of the participants.

By mid-February, with about two weeks of the research period remaining, the investigator met with the Assistant Director of Social Work, the OB social worker, a social work student and the student's supervisor, to discuss the progress of the support group program and to plan for the group's future. It was decided that, after sitting in on at least one group session and being oriented by the investigator, the student would co-lead the group until her field placement ended, at which time other arrangements would be decided upon by the Social Work department. The investigator also consulted with the

Nurse Educator and the PCC as to the future of the group. The Nurse Educator said that she would like to continue to co-lead the group sessions, and the PCC planned to sit in.

The abovementioned events encouraged the investigator to feel hopeful about the institutionalization, or at least temporary continuation, of the support group program. During the last two weeks of the study, as the investigator's time on the Post-Partum unit drew to a close, the social work student and OB social worker, as well as a graduate nursing student, sat in on a group session; all felt it was manageable. The Nurse Educator and several staff nurses voiced regrets about the investigator's impending departure. By the end of the study period, the social work student seemed confident about taking over the co-leadership, and the Nurse Educator about continuing the collaboration. Therefore, it came as somewhat of a surprise to find that, within a few weeks of the investigator's leaving, the support group program had been discontinued. The reasons given by the Assistant Director of Social Work were that the social work student had had a very difficult time recruiting mothers to participate, and that no staff member could be spared to take over after the student's field placement ended.¹⁰

Evaluation Stage

After each support group session, the study plan called for the investigator to visit each mother in her room and to explain (in more detail than at the group session) that the support group program was relatively new, and that the investigator would like to know what each participant thought about what had happened in the session, in order to make the groups as helpful as possible. The investigator was then to ask each mother to rate both the educational and support components of the group session, and to respond to some open-ended questions about the group experience (see Appendix II, Feedback Form). The logical time for this feedback interview to take place would have been immediately following the group session. However, this was both lunchtime and visiting hours, so although the investigator approached each mother at this time, for many mothers it was necessary to make an appointment to come back later. Each mother did get interviewed within four hours of the group meeting, but the length and content of the individual feedback sessions varied widely, as some mothers wanted to continue talking about issues raised in the group, others responded to the questions at length, and still others were eager to get the questions over with so that they could take phone calls, rest, or engage in other activities.

As the feedback sessions varied, so did the

follow-up interviews, which were held by telephone at approximately twelve weeks post-partum. Difficulties in finding convenient times to conduct telephone interviews of at least half an hour with mothers who not only had three-month-old infants, but were also likely to be working, often led to repeated telephone calls and rescheduling. Cranky babies and tired mothers notwithstanding, forty-four of the original fifty participants were eventually interviewed, and the majority of them were generous in sharing their experiences and responding to the investigator's questions. The data obtained from both feedback and follow-up interviews will be analyzed in the following chapter.

SUMMARY: PROMISE AND REALITY

In summary, though the support group program was developed utilizing strategies derived from a "non-client-centered" approach¹¹ which included knowledge of the pitfalls likely to be encountered when dealing with a large, multifaceted, hierarchical system, it was impossible to foresee exactly where systemic snags would arise. The delays in the initiation phase seemed related both to the investigator's status as an outsider and to the Social Work department's status as a non-medical, non-research-oriented, nonaggressive and only moderately collaborative entity. Some delays in the

implementation phase had to do with Legal Services' disinterest in, or lack of familiarity with, non-medical research studies, as well as with the Social Work department's status. Further obstacles to beginning the support groups on the Post-Partum unit on schedule ostensibly had to do with nursing staff shortages, but the issue of legitimation of the investigator was also important: It was not until the investigator was able to spend time on the unit and talk to the nurses individually, as well as to demonstrate willingness to cooperate with the PCC in not disrupting the activities of the unit or taking up staff time in order to conduct the groups, that both staff nurses and PCC became more involved in the program. Despite the eventual approval of the unit staff and the enthusiastic response of the participants, institutionalization of the program failed to occur. Here, too, the issue of staff overload--this time, social work staff--was raised, though an attempt was made to continue the program temporarily. However, since the investigator was not part of the staff, the collaborative effects that had been achieved during her tenure dissipated after she left the setting. Perhaps the most that can be said at this time is that the best-organized, most thoughtfully presented and thoroughly-researched programs can still be no better, in fine, than the systems in which they are implemented.¹²

REFERENCES

1. Bruce S. Jansson and June Simmons, "Building Departmental or Unit Power Within Human Service Organizations: Empirical Findings and Theory Building," Administration in Social Work, 8 (Fall 1984): 41-56.
2. Ibid.
3. Jack Rothman, "Promoting an Innovation," Change from Within, ed. Herman Resnick and Rino Patti (Philadelphia: Temple University Press, 1980), pp. 241-42.
4. Julie Abramson, "A Non-Client-Centered Approach to Program Development in a Medical Setting," Agency-Based Social Work, ed. Harold Weissman, Irwin Epstein and Andrea Savage (Philadelphia: Temple University Press, 1983), pp. 178-186.
5. Alfred J. Kahn, "Institutional Constraints to Interprofessional Practice," Medicine and Social Work, ed. Helen Rehr (New York: Prodist, 1974), pp. 14-25.
6. For a discussion of roles and responsibilities of the social worker and nurse-clinician in interdisciplinary teamwork, see Jane I. Lowe and Marjatta Herranen, "Conflict in Teamwork: Understanding Roles and Relationships," Social Work in Health Care, 3 (Spring 1978): 323-30; and "Understanding Teamwork: Another Look at the Concepts," Social Work in Health Care, 7 (Winter 1981): 1-11.
7. John Wax, "Developing Social Work Power in a Medical Organization," Social Work, 13 (1968): 62-71.
8. Harold Weissman, Overcoming Mismanagement in the Human Services, (San Francisco: Jossey-Bass, 1973), pp. 9-24.
9. By contrast, the investigator had an opportunity to implement the support-group program on an informal basis, for a limited time, within the hospital where she was employed. The Nurse Educator, PCC and nursing staff there were extremely hospitable to the implementation of the program, and publicized the support groups not only by way of attractive, noticeable posters in patient rooms, but by direct recruitment on the part of the PCC.
10. As this chapter was being written, the investigator received a phone call from the OB social worker at "East Side Medical Center". It seemed that the new Director of

Maternal-Child Health Nursing planned to institute a new program for Cesarean mothers. Social Work had learned of the program--which called for continuity of nursing care for Cesarean mothers, rather than having nurses rotated each day--only by chance. The OB social worker had asked to sit in on the discussions and in-service lecture, but wanted to know whether the investigator's findings regarding the support group program were available. The new Director of Maternal-Child Health Nursing had never heard of the support group program, nor were there any plans afoot to reinstitute it, as far as the OB social worker knew. The investigator agreed to provide information from the findings of the support group study, and offered to attend the in-service lecture as well, in the interest of improving patient services as well as raising staff consciousness regarding the efficacy of support groups. Perhaps, now that some evidence exists as to patient satisfaction with the support group intervention, and a precedent has been set for conducting such groups, the program will be revived.

11. Abramson, "A Non-Client-Centered Approach."

12. Bess Dana, H. David Banta, and Kurt W. Deuschle, "An Agenda for the Future of Interprofessionalism," Medicine and Social Work, ed. Helen Rehr (New York: Prodist, 1974), pp. 77-88.

CHAPTER IV

FINDINGS

THE SUPPORT GROUPS

A DESCRIPTION OF THE STUDY SAMPLE

A total of 50 women participated in the Cesarean support groups during the two-month research period. Of these, 40, or 80%, were white, 6 (12%) black, 3 (6%) were Hispanic and 1 (2%) was Asian. Forty-five of the women were private patients and 5 (2 white, 3 black) were Clinic patients. Forty-five were married and 5 were single. Their ages varied greatly, ranging from 21 to 48.

The reasons for having had Cesarean delivery (as obtained from medical records) included: breech presentation, where a part of the body other than the head was emerging first (9 mothers, or 18%), fetal distress or jeopardy, which could be due to a number of causes (9, or 18%), failure to progress, where the infant was not moving through the birth canal in a timely fashion (8, or 16%), cephalopelvic disproportion, where the child's head was too large for the cervix (7, or 14%), pre-eclampsia, or high blood pressure in the mother (6, or 12%), repeat Cesarean (5, or 10%), transverse arrest, where the infant had literally gotten stuck in the wrong position (3, or 6%), maternal herpes, maternal diabetes, and toxemia (each, 1, or 2%).

THE GROUP SESSIONS

The Cesarean support groups were to meet at least twice a week to discuss the physical and emotional stresses of Cesarean birth, to offer suggestions for self-care and facilitate coping, and to provide peer support. A total of 19 group sessions were scheduled; 18 were held as planned, and only one had to be cancelled because, of the mothers with Cesareans on the Post-Partum Unit on that day, none chose to/were able to attend.

Of the mothers with Cesareans on the Post-Partum Unit on any given day (ranging from a low of 5 mothers to a high of 15, with an average of 10), an average of 31% participated in the group. (On one day, no one attended; on another day, as many as 5 out of 7 attended.)

Table 1: Group Attendance

<u>Size of Group</u>	<u># of Groups</u>
0	1
1	4
2	3
3	4
4	3
5	3
6	1

When mothers did not attend, the reasons they gave were as follows:

- Too soon after surgery. Due to considerable pain and physical discomfort, no mother was able to attend on post-operative day 1, and many did not feel physically able to attend on day 2.

- Preparing to go home.

- Too uncomfortable.

- Busy nursing baby, or expecting company or a visit from doctor.

- Having stitches removed.

- Didn't speak English.

In addition to the mothers themselves, various other individuals attended/sat in on the sessions from time to time (but were not counted as members): husbands; a patient's mother; a patient's private-duty nurse; staff nurses and nursing students; social workers and social work students.

FEEDBACK INTERVIEWS

As soon as possible after each group session, each mother was seen individually in her room and asked to respond to a feedback questionnaire administered by this writer (see Appendix II).

Education and Support

In attempting to measure whether the program

objectives had been met, the mothers were asked to rate, on a scale of "not at all" through "very much", the extent to which the group sessions added to their knowledge of the Cesarean birth process. The attempt here was to discern the extent to which the participants felt they now knew more about the actual surgical procedure itself.

Although nearly two-thirds of the mothers felt that the process of Cesarean birth per se had not been covered specifically in the group, 13 mothers, or 26%, learned "quite a bit" or "very much". The leaders did mention the surgery in the context of explaining the different types of incisions performed, different kinds of anaesthesia utilized, different sutures, and the actual cutting through various layers (skin, fatty tissue, muscle, uterus); however, the responses suggested that many mothers already possessed some general knowledge.

Table 2: How much do you think the group increased your knowledge and understanding about the Cesarean birth process?

(N=49)

Rating	#	%
Not at all	9	18
Very little	23	47
Somewhat	4	8
Quite a bit	8	16
Very much	5	10

However, when asked for specific information about what they had learned, 27 mothers responded. Their answers appeared to fall roughly into three categories: the concrete/educational, the supportive/empathic, and the already-informed. Concrete answers (8 responses) tended to deal with actual details of the surgical process ("Layers...cutting...sewing"); empathic responses (10 answers) tended to emphasize the universality of the experience ("Many women go through it...nothing to be ashamed of," "Everybody has fears; I'm not the only one that feels that way"); already-informed answers (11 responses) were from those who already thought they were

familiar with this content ("I already knew," "Had heard from my doctor and the Labor nurses," "Had gotten the information in the prenatal class," "I am a nurse").

Table 3: If you learned something about the Cesarean birth process, what was it? (N=29)

Rating	#	%
Concrete	8	27
Supportive	10	34
Informed	11	38

One of the purposes of the group sessions was to inform the mothers about such surgical sequelae as pain, weakness, discomfort due to catheters and IVs, gas pains, swelling of hands and feet due to fluid retention, excessive perspiration and urination, etc., and to let them know that these were normal symptoms. Clearly, the vast majority of mothers (92%) felt that the group had indeed increased their awareness of, and understanding of the reasons for, these stresses.

Table 4: How much do you think the group increased your knowledge and understanding of the physical stresses often experienced in the first few days after delivery? (N=50)

Rating	#	%
Very much	11	22
Quite a bit	21	42
Somewhat	14	28
Very little	4	8
Not at all	0	0

Twenty-five mothers gave a total of 27 specific responses to the open-ended portion of the question, "If you learned something about the physical stresses, what was it?"

Again, there appeared to be three categories:

concrete/educational, empathic/supportive, and informed.

Table 5: If you learned something about the physical stresses, what was it?

(N=27)

Rating	#	%
Concrete	9	33
Supportive	12	44
Informed	6	22

The 9 concrete/informational responses focused around specific symptoms, such as:

- "How long it takes to heal. Pain."
- "Incisions, staples."
- "Gas pains."
- "How long [pain] lasts."
- "Will still be in pain after going home."

While pain was an important common ground, mentioned by most mothers during the group sessions as the most difficult and unexpected outcome of the Cesarean surgery, only a few mothers (as above) referred to it specifically after the group meetings.

The 12 empathic/supportive responses mentioned the feeling of sharing a common experience and thus feeling less isolated:

- "[It] reinforced--validated--what I was going

through by hearing it from other women."

- "Awareness of how different people react to [the surgery]."

- "Mine are like other people's."

- "It's different for everybody."

The 6 informed responses essentially spoke of the respondent's prior knowledge of physical stresses, or of their wishes to have known more::

- "I knew about the pain before."

- "Had read about it and learned in the Lamaze classes."

- "I still don't fully understand."

- "Would have liked to know about it before [the Cesarean]!"

The subgroup of mothers who wished they had known more, in contrast to the majority of mothers (see Table 4), seemed to feel they hadn't learned much about physical stresses from the session.

Another purpose of the group sessions was to provide information to the mothers as to the occurrence and types of emotional stresses, such as feelings of sadness, anger, etc., that are a normal outcome of Cesarean surgery, and to discuss common emotional reactions with them.

More than three-fourths (78%) of the mothers responded that the group had indeed increased their

awareness of, and comprehension of the causes for, the emotional stresses.

Table 6: How much do you think the group increased your knowledge and understanding of the emotional stresses often experienced in the first few days after Cesarean delivery? (N=50)

Rating	#	%
Very much	12	24
Quite a bit	17	34
Somewhat	10	20
Very little	8	16
Not at all	3	6

When asked about the emotional stresses of Cesarean birth, thirty-eight mothers enumerated what they had learned, with a total of 39 responses. Again, most of the responses seemed to fall within the concrete/educational and supportive/empathic categories. Nineteen mentioned specific items of information, such as:

- "Mood swings."
- "Worries about the baby and not doing it right."
- "Blues, etc."

Fourteen mothers mentioned the commonality of feelings:

- "Others feel the same way...there is a disappointment, and lots of emotional issues."

- "Other people have the same feelings--[I feel] less isolated."

A number of mothers, while stating that they learned that emotional stress was a common experience following Cesarean delivery, added, "Maybe some people experience it--I don't feel that way," "It bothers some people (but not me)." These responses suggested that the content was not felt, by these particular mothers, to be relevant to their experiences. Only one mother mentioned that she had known about the factor of emotional stress beforehand, as it had been mentioned in her prepared childbirth class.

Table 7: If you learned something about the emotional stresses, what was it?

(N=39)

Rating	#	%
Concrete	19	49
Supportive	14	36
Not applicable	5	12
Informed	1	3

In the next group of questions (4a, 4b, 5a and 5b), the emphasis was shifted from an attempt to ascertain how much information the mothers had received from the group regarding the given components of Cesarean birth to how much they felt that the group had provided them with the sense that they had skills or resources available to cope with the physical and emotional components or experiences. Of the mothers responding, 78% indicated that they had received some information from the group in regard to coping with physical components.

Similarly, the mothers were asked about specific ways in which they felt they had learned to cope with physical stresses. Of the 34 mothers responding, two-thirds mentioned concrete items discussed in the group sessions. Typical responses to their feelings of increased capacity to cope with physical stresses were:

- "By asking for--and getting--help with them. You need time to recuperate."

- "How to cope to get yourself out of here--e.g., stitches, food, gas pains, etc.--what happened and what to do."

- "Learned how to care for myself and the baby at home."

A few mothers mentioned that listening to other group members was helpful:

- "You might hear about how someone else dealt with it."

- "It's helpful that people understand what you're going through."

The remaining one-third of the responses were either from those who already knew about what was discussed: "I had friends with Cesareans," or were, perhaps, not interested in what the group had to say on the subject: "I'm basically my own person."

Table 8: "How can you now deal with these [physical stresses]?" (N=34)

Rating	#	%
Concrete	23	67
Supportive	4	12
Not applicable	4	12
Informed	3	9

Sixty-six percent of the mothers perceived the group session as providing them with a sense that they had skills/resources available to handle the emotional reactions that are a frequent outcome of Cesarean delivery.

Of the 24 responses to the question about increased capacity to deal with emotional stresses, two-thirds were concrete/educational:

- "Talk about it."
- "Ask for help."
- "Get support--and give it."

It was clear that the importance of emotional support had been recognized by these respondents, as they all emphasized that the emotional stresses were normal and needed to be talked about, and that they would do well to find friends, other Cesarean mothers, and/or physicians who could listen and provide such support.

Five mothers indicated that this issue either hadn't been covered in their group sessions or wasn't relevant to them, two indicated that they were aware of this issue ("I knew already--friends had Cesareans,") and one replied, "I was reluctant to come, but it helped me to be around others."

Table 9: How can you now deal with these [emotional stresses]? (N=24)

Rating	#	%
Concrete/educ.	16	67
Supportive/empath.	1	4
Not applicable	5	21
Informed	2	8

Question 6, which asked, "How useful do you think it is for Cesarean mothers to meet with others in the same situation?" tapped the participants' perception of the idea of discussing common issues of Cesarean delivery with others as being helpful to them in some way. Forty, or four-fifths of the mothers, gave the highest rating when asked this question; an additional 7 rated it as "quite a bit", and 3 as "somewhat". These last 3 mothers had had unusual circumstances around their group sessions: one of them had been the only participant on that day, so the "group" had consisted of herself, the social worker, and the nurse-educator. The other two mothers had constituted a group (along with the two leaders), but a family member of one of them had come into the meeting and had proceeded to draw the mother's attention away from the discussion,

so that she and the other mother had not really had an opportunity to talk with one another.

Table 10: How useful do you think it is for Cesarean mothers to meet with others in the same situation? (N=50)

Rating	#	%
Very much	40	80
Quite a bit	7	14
Somewhat	3	6
Very little	0	0
Not at all	0	0

Participants' Comments and Suggestions Regarding Group

The last part of the questionnaire asked the participants what they liked best and least about the group, and asked for changes they might make in specific areas (length, location, content, etc.), as well as any additional comments or suggestions about the group. These questionnaire items elicited open-ended responses, which are discussed below.

Of the 49 mothers who answered question 7, "What did you like best about the group?" nearly three-fourths mentioned support only ("Meeting with others and learning from their experiences," "The support, communication and

acknowledgment that people know you've been through something other than normal delivery"), four mentioned education only ("The leaders were experienced and knew what they were doing," "Learning more about the [Cesarean birth] process"), and nine mentioned both support and education ("Ventilate. Share with others who had the same experience. Get information from others").

Table 11: What did you like best about the group? Please explain. (N=49)

Aspect	#	%
Support	36	73
Education	4	8
Both (supp.& ed.)	9	19

Comparatively few of the participants chose to answer the question, "What did you like least about the group?" The remainder said they liked everything, or couldn't think of anything they didn't like. Of those responding, 4 thought the group was too short, 2 felt that (in their sessions) other members had "shown off" or monopolized the group's attention, 3 gave non-related answers (complaints about the hospital or concerns about their babies, but nothing about the group), and one

"expected it would be more educational--like a class."

The mothers next answered a series of questions about whether they would make any changes in the group. All of the 5 responses about "number of sessions" had to do with the request for additional/more frequent group sessions, with the idea that some mothers might/would want to attend more than once.

Of the 9 mothers responding to "length of sessions", most indicated that they would have liked longer sessions--one suggested one and one-half hours instead of the 45-50 minutes we had scheduled. One mother requested that the sessions be a bit shorter--about 30-40 minutes--and the remaining mother wanted a flexible amount of time, "as long as everything is covered."

There was no consistency in the 5 answers about "material that was covered". The suggestions/requests ranged from more specific questions regarding emotions, to more information on surgery, to more delineation of "what to expect now and after going home". More emphasis on the theme that "lots of people have Cesareans and it's okay" and "vaginal birth is not the only way" was also requested, and one mother recognized that "each group will have different questions".

There were no responses to the item, "sequence of material", nor to a later item, "participants".

The two answers to the "format" section were

requests for more information: one, on how to alleviate pain, and the other, for a card in each patient room with "vital information: the hospital address, the room and phone numbers, and an agenda of classes and hospital procedures".

Of the two responses about the group leaders, one was a positive comment on the "warmth and empathy of the leaders. It's nice to have a woman to talk to about it." The other response was a request for more [leader] input and structure.

Thirteen mothers had suggestions about "arrangements". Two answers echoed the request to make information about the group more available beforehand: "Post information about it so people can plan activities." "Put it in the handout and/or tour brochures." Five mothers asked that the group meet in the late afternoon, rather than at 11 a.m., as scheduled. One mother requested that the group meet "right after breakfast or at 11:15 promptly--[we] need time to get ready for visitors." Another mother voiced a similar sentiment: "...as long as it doesn't interfere with the schedule [of activities, visitors, etc.]." And two more mothers felt it was "too close to lunchtime". The other two answers did not address the time of the meeting--one felt the arrangements for both time and location "need to be scrutinized," and the other was critical of the room in which the group met,

which was "...airless and needs more light".

Four mothers responded to the "other" category, each with a different suggestion: to include a question period, to "...try to give the group sooner during the [hospital] stay," to include visual aids, and (echoing issues in items e and h), to have "advance notice--a sign, etc., about the time of the group."

Finally, twenty-five mothers responded to the question, "Any additional comments about the program?" with a total of 45 specific comments, suggestions and criticisms. Eight comments were positive remarks about the group: it was good; it should continue; it was appreciated; helpful; informative. One of these mothers especially liked being invited to the group (by the social worker).

Eight comments indicated that additional information about specifics--such as physical self-care after Cesarean surgery, the Cesarean process itself compared to vaginal delivery, the effects of antibiotics/painkillers on breastfeeding, dressing removal, gastrointestinal symptoms, IVs, etc.--would be helpful, both during the group sessions and in the handouts. The latter, they suggested, should be made available as soon as possible after delivery. One of these mothers wondered whether there could be an informational/educational session for husbands.

Seven mothers mentioned the importance of support, empathy and talking about emotions: "[The leaders] might want to talk about the anticipatory anxiety and the post-discharge emotions." "Psychologically, it's good to talk to other mothers who have the same experiences and problems." One of these mothers suggested that "a social worker come by as a matter of course and talk about Cesareans and what to expect," while another asked, "Could an experienced Cesarean mother come and talk to a person on the first or second day after delivery?"

Not all of the comments were directly related to the support group program. For example, 5 mothers said, "Cesarean mothers should room together," and 5 mothers asked that information about Cesarean birth be available beforehand. Six comments, positive and negative, concerned the physical arrangements or the staff: "The nurses and doctors helped [me] beforehand...to feel confident and less fearful." "Nurses in Labor and Delivery kept telling me if I didn't do X or Y I'd have a section." "We need better communication with the nursery...about rules and what they do and what you have to do." "The rooms are dirty!"

A few miscellaneous suggestions, such as the use of visual aids, expanding the handout pamphlet, more frequent sessions, and a post-discharge group, were offered as well. One mother also commented that she felt

uncomfortable having visitors in the group, and that their presence might impede spontaneity.

SUMMARY OF FEEDBACK INTERVIEWS

The individual "feedback" evaluations of the support group, following each group session, indicated that the participants considered both the educational and the support components of the program important. There was no substantial criticism of the content, format or leadership of the sessions, except that a considerable number of mothers indicated that they had already obtained information about the specifics of the Cesarean surgery prior to attending the group sessions. Not only did the mothers think that the group had provided them with information about the physical and emotional stressors of Cesarean birth--they also felt that concrete suggestions had been offered to help them to cope with those stressors. The fact that the mothers were able to enumerate the suggestions, after the group sessions, demonstrates that learning did indeed occur; thus, the program objective of providing education was achieved.

The response to the question about peer support elicited the most positive response of any item in the feedback evaluation. All the mothers indicated that it was useful to meet with others in the same situation; it was not only the information (offered by the leaders) that

was perceived as helpful. Further, when the mothers were asked what they liked best about the group, the vast majority mentioned the support aspect. Thus, the objective of providing support was achieved, even more resoundingly than that of providing information.

The items inviting suggestions for future groups, while not answered by all the mothers, produced responses primarily requesting more frequent sessions, longer duration of sessions, and more information about the sessions beforehand. These suggestions were immediately considered, and action was taken, if appropriate. Accordingly, the frequency of group meetings was increased at one point during the research period; this resulted in a larger attendance per week, but a smaller number of participants per group, than the original schedule had yielded. Most mothers found that they could not physically handle sessions longer than about 45-50 minutes, so that longer duration of sessions was not practicable. The sessions were publicized, by staff nurses and written notices, following suggestions about more information beforehand, but it appeared that the personal invitation by the investigator was what motivated most mothers to attend.

Additional comments about the program were solicited, and yielded--in addition to requests to include more education and statements that the group was good, the

support important, etc.--comments about the staff, the physical environment of the unit, and hospital policies. These were to be fed back to the proper departments by way of the Nurse Educator who co-led the groups.

RESULTS OF TELEPHONE INTERVIEW

Three months after each mother participated in the Cesarean Support Group, the investigator attempted to contact her by telephone. Each mother who was reached was reminded that the investigator had said there would be a follow-up, and was asked to answer some questions about herself, the support group, and the Cesarean experience. Of the fifty mothers who had participated in the group, 44, or 88%, were interviewed by telephone.

Detailed questions about the mothers' experiences were asked at this time, rather than at the time of the support group intervention, in order to obtain a retrospective view of the experience from the vantage point of a different stage in the mothers' recovery process. Further, much of the information could not have been obtained until after the mothers' return home. The telephone interview consisted of 39 questions, some of them with more than one part, which asked for background information, birth plan and preparation, actual experience of Cesarean birth, experiences and feelings during the immediate post-partum period, perceptions of support, and

recommendations. (See Appendix III.)

DESCRIPTION OF THE FOLLOW-UP SAMPLE

The sample of mothers interviewed by telephone was not appreciably different from the original, slightly larger group of participants in regard to age, ethnicity or patient status. The mean age of the mothers interviewed was 31.9 years. Seven (16%) were 21 to 25 years old; 10 (23%) were 26 to 30; 16 (36%) were 31 to 35; 10 (23%) were 36 to 40; the remaining mother was 48. Thirty-six of the mothers (81%) were white, five (11%) were Black, and three (8%) were Hispanic. Forty mothers (90%) were private patients, and four (two white, two black) were clinic patients.

The length of hospital stay (LOS) following the Cesarean delivery varied from four to seven days, though one mother stayed for eight days and one (who became severely ill following delivery) remained in the hospital for three weeks. The mean LOS was 5.8 days, slightly less than the average 6.1-day LOS for Cesarean mothers in 1987.¹

Six mothers (14%) were high school graduates with no further formal education; 3 (7%) had attended, but not completed, college; 18 (41%) were college graduates, and of these, three had additional post-graduate education but no post-graduate degree; 17 (39%) had graduate or

professional degrees, including M.S.W.s, law degrees, master's degrees in education, art history, counseling, special education, occupational therapy, nutrition, and retailing; one had an M.D.

Although 16 mothers had said, when admitted to the hospital, that they were not currently working/on leave/unemployed, only two of them, at the time of the follow-up interview, identified both their current and previous employment as "housewife". Many mothers had gone back to work after a brief maternity leave; the others considered themselves only temporarily unemployed. Thirteen mothers (30%) were in the business world (banking, insurance, computers), 13 (30%) were professionals (M.D., attorney, social worker, etc.), 5 (11%) in artistic/literary pursuits (art director, writer, filmmaker, etc.), 5 mothers (11%) listed their jobs as secretarial/clerical, 4 (9%) were teachers, 2 (5%) were students, and 2 (5%) were housewives. The educational and occupational information yields a picture of a population much better-educated and employed at higher-level jobs than the average; it would be well to keep this information in mind in examining the women's experiences and responses to the interview items.

Forty of the mothers were married; 4 were single. One of the married mothers had previously been divorced and had a child by the previous marriage. The mean

duration of marriage was 5.4 years. All of the unmarried mothers seemed to be involved in relationships with the fathers of their children, and they all gave current information regarding their partners' work, education, age and ethnicity.

Ten of the partners (23%) were employed in construction, service, clerical or civil service jobs. Thirty-two (72%) were described as businessmen or professionals, including bankers, stockbrokers, systems analysts, attorneys, social workers, sound engineer, doctor, professor, etc. Eight of the partners (18%) were high school graduates; 6 (14%) had some college; 13 (30%) had attained a Bachelor's degree; 16 (36%) were professionals (attorneys, social workers, M.D., Ph.D.). The mean age of the partners was 35.7 years. Thirty-seven of the partners were white; 4 were Hispanic; 2 were Black.

Again, the partners reflected educational and employment levels (and, by inference, income levels) above the average. Paternal ages were higher than the national average and the ethnicity of the sample over-represented whites when compared to the population of the city in which the hospital was located.

For thirty (68%) of the mothers in the follow-up sample, the child delivered at the time of the study was their first. One mother had delivered twins. Eleven

mothers had one other child; 2 mothers had two other children. These children ranged in age from 2 1/2 to 16. All were 7 years or younger, except for the 16-year-old, who was the child of an older mother, from a previous marriage.

For forty of the mothers (91% of the respondents), this was the first Cesarean delivery. Four of the mothers had had previous deliveries by Cesarean section; 12 mothers had had previous vaginal deliveries. Thirty-four mothers (77%) were the first in their families to deliver by Cesarean section; for the remaining 10, family members such as aunt (2), sister (4), cousin (3) and mother (3) were mentioned. In some families, more than one member had had a Cesarean delivery.

Birth Plan and Preparation

The mothers were asked a number of questions about their original plans and preparation for childbirth, in an attempt to discern the differences between their expectations and the actual experience. Thirty-nine, or 89%, of the mothers had planned to have vaginal deliveries using techniques of "natural" childbirth such as are taught in Lamaze classes. Two more mothers had planned vaginal deliveries, but with epidural anaesthesia; therefore, a total of 93% of the mothers expected to deliver vaginally. The remaining mothers had either planned Cesarean deliveries, or had had previous Cesarean

deliveries and had assumed that this one would be the same. Forty-three of the mothers had planned to have their babies in a hospital; the other mother had planned to deliver at a birthing center, and was sent from there to the hospital after complications arose.

Thirty-nine mothers (89% of the sample) attended prenatal classes; all but one of their partners attended as well. Of the remainder, one mother did not attend because she was an M.D. and had had obstetrical experience and one mother had planned to attend but delivered prematurely. Twenty-eight mothers (64%) stated that the prenatal classes that they had attended included information about Cesarean birth. Nine mothers reported that no information was given, or that they didn't listen, didn't remember, or missed the class session devoted to Cesarean birth. One other mother had attended a special class on Cesarean birth. The class material dealing with Cesarean birth included the following topics:

- type of anaesthesia (reported by 10 mothers)
- a review of the entire Cesarean process (9 mothers)
- reasons for Cesarean delivery (8 mothers)
- types of incisions (4 mothers)
- recovery from Cesarean delivery (4 mothers)
- preparing for the possibility of a Cesarean (3 mothers)

- medication, position of baby, pain
- literature and statistics
- feeling "less of a woman" after Cesarean delivery
- post-partum depression
- husband's role after a Cesarean delivery
- "try to avoid it like the plague"

Nine mothers stated that there was limited time and/or information due to so many other issues being covered in the classes; two mothers felt that information was given only because class members requested it; only one mother's instructor solicited questions about Cesarean delivery.

When asked whether their obstetricians had discussed Cesarean birth during the prenatal period, 28 mothers (64%) said that they had not. Of the fifteen who said that Cesarean birth had been discussed with their obstetricians, the information given was characterized as everything from "very little" to "quite a bit". One patient, with vaginal herpes, had extensive discussions with her doctor; another, whose baby had been in breech position from 5 months on, had also discussed Cesarean delivery. Despite the fact that one-third of the mothers mentioned talking with their doctors beforehand, most of the doctors' comments about Cesarean delivery appeared to be in the "not much chance" or "it probably won't happen"

category. One woman said, "The day I gave birth, the doctor said there was a 99% chance I wouldn't need one!" Specific information mentioned had to do with options for delivery, and types of anaesthesia.

Thirty-one of the mothers (70%) had not discussed Cesarean birth with anyone else prior to delivery. Of the remainder, 9 (20%) had talked about it with friends, three (7%) with relatives and one with a neighbor (some respondents mentioned more than one source). When asked about the content of these discussions, most of the mothers could not mention anything specific, except hearing about others' experiences.

The "typical" mother in our sample, therefore, had heard about concrete aspects of Cesarean delivery in the prenatal class, but had not discussed Cesarean birth with her obstetrician or with anybody else prior to delivery, and had gone into labor assuming that she would have natural childbirth and a vaginal delivery, without information about the psychological or physical pain of Cesarean birth.

Each mother was asked why she thought she had had to have a Cesarean; the answers were compared with the actual reason given in the medical record (for which there were reasons stated for 42 of the 44 respondents). The answers given by two-thirds of the mothers corresponded almost exactly with the reasons stated in the medical

records. The other one-third of the sample gave either vague answers or responses that differed from those on the official records. Interestingly enough, three of the four mothers who had had previous Cesarean deliveries were among this group; the official records noted "Repeat Cesarean" and the mothers gave such reasons as "Didn't dilate--failure to progress," "Baby too big," and "My membranes ruptured." The usual response given to mothers by obstetricians, when the question of repeat Cesarean comes up, is that there is no reason why a vaginal delivery cannot be attempted, and that a Cesarean will be done only after labor has progressed and it is clear that complications would otherwise ensue. However, given the discrepancies between the mothers' reports and the official reasons as noted above, perhaps this explanation is more a matter of lip service than a reality.

The mothers were asked how long before the actual Cesarean delivery they had been aware that it would take place. Eighteen mothers (41%) had been told less than one-half hour prior to the surgery that they would have a Cesarean birth. Some of these women commented that they had had only 3 to 5 minutes' notice, after many hours of painful labor. Seventeen mothers (39%) reported that they had been informed during labor, usually within 1 to 3 hours before the actual Cesarean surgery was performed. Again, many comments were made about the long, painful

labor they had endured before the Cesarean delivery; two mothers said they had been told there might be a chance of Cesarean section, but had had a trial of labor. The 9 remaining mothers (20%) had known at least one day before delivery that a Cesarean section would be performed and/or scheduled. One of these women had positive herpes, one knew at least two weeks ahead of time, two knew a month beforehand, and one knew at least two months prior to delivery.

Thus, four-fifths of the mothers had from only a few minutes to 3 hours' notice that delivery would be by Cesarean section, certainly not a great deal of time to process, let alone integrate, this news, especially within the context of active and sometimes painful labor.

When asked to remember and describe their reactions upon learning that they would undergo a Cesarean delivery, a number of mothers mentioned more than one type of reaction. The responses ranged from "apprehensive," "fearful," "anxious" to "confident," "happy," "relieved". The responses can be categorized as follows: Thirty-five mothers, or 61% of the follow-up sample, were concerned (anxious about baby's well-being, apprehensive, frightened, upset, "out of it", exhausted, devastated, stunned); 13 mothers (23%) were neutral (expecting it, "get it over with," other factors more important, "didn't bother me"); and 9 (16%) were relieved (happy,

confident). Clearly, the majority of the mothers were not happy to learn that they would deliver by Cesarean section, and many of them had strong reactions to the news.

The "typical" mother, then, had a fairly good understanding of the reason why it had been necessary to perform the Cesarean surgery. She had had little advance warning that the Cesarean would be necessary, and in fact might have been reassured to the contrary. As she was, in all likelihood, exhausted from painful labor and apprehensive as to her infant's well-being, she felt she had little choice but to agree to the surgery, despite a variety of strong emotions.

(Given the fact that a majority of the mothers had not discussed Casarean birth with anyone prior to delivery, and had heard only a few concrete facts about Cesarean delivery in their childbirth classes, one wonders whether it was really possible for them to make an informed choice at this critical point. A question as to whether the mothers thought they would make the same decision again, if given the opportunity, was not included in the study, but perhaps it should have been.)

Actual Birth Experience

Several questions were asked about the actual experience of Cesarean delivery, including type of anaesthesia, presence of partner, and feelings immediately following delivery. The mothers were asked what type of anaesthesia, if any, had been used during the Cesarean surgery. Thirty-four mothers, or 77% of the respondents, had had epidural anaesthesia, in which the mother remained conscious but had no sensation in the lower half of her body. Nine mothers, or 20%, had had general anaesthesia. One mother (the M.D.) had had no anaesthesia. Many of the mothers volunteered additional comments about the anaesthesia; the majority of these comments, both positive and negative, had to do with their attitudes toward epidural anaesthesia.

In response to the question as to whether her partner was present during delivery, each of the mothers said her partner was not present. This had been a topic of heated discussion in the support group. Most mothers had wanted their partners to be there, but the hospital policy was to forbid their presence in the delivery room, whether or not the father had attended a special class, was himself an M.D., etc. A good deal of criticism was directed toward this policy, both by the mothers, the fathers, the nursing staff, and others. According to the Nursing Department, it was the

Anaesthesiology department that was responsible for the policy. The OB department was not averse to allowing fathers in the delivery room under certain circumstances. However, the rationale of the Anaesthesiology Department was that if a father were to faint or otherwise experience difficulties during the Cesarean delivery process, the anaesthesiologist would have to revive him and thus would not be fully available to the mother.

The mothers were asked to remember and describe the feelings they had had immediately after the Cesarean. Many mothers mentioned more than one feeling, for a total of 56 responses. These fell roughly into four categories: Physical feelings, such as pain, shakes, numbness, breathing problems; emotional feelings--positive (happiness, surprise, relief, elation, excitement); emotional feelings--negative (frustration, disappointment, fear, worry, inadequacy, shock); and other feelings (drugged, out of it, disoriented, groggy).

Table 12: Feelings Immediately After Delivery

<u>Type of Response</u>	<u># mothers</u>	<u>%</u>	<u># responses</u>	<u>%</u>
Physical	7	16	10	18
Emotional (+)	18	41	23	40
Emotional (-)	14	32	15	27
Other	8	18	8	14

The emotions, positive and negative, accounted for the majority of responses: 73% of the mothers, and 67% of the responses. Clearly, the period immediately following Cesarean delivery is one where emotions are strong.

IMMEDIATE POST-PARTUM PERIOD

Bonding

Since one of the concerns of previous studies had been the extent to which delivery by Cesarean might affect the mother-infant bonding process by delaying the time at which a mother could first hold, feed and/or nurse her infant, a number of items asking for maternal reactions to, and experiences with, the new baby were included in the questionnaire.

To begin with, the mothers were asked to remember the thoughts and feelings they had had about the baby immediately after delivery. The 67 responses fell into three categories: Relieved/happy (positive, thrilled, elated); Concerned/unhappy (worried about baby, cheated, didn't feel attached at first); and Other (surprised, stunned, tired).

Table 13: Thoughts and Feelings About Baby

<u>Type of Response</u>	<u>#mothers</u>	<u>%</u>	<u>#responses</u>	<u>%</u>
Relieved/happy	27	61	33	49
Concerned/unhappy	14	32	21	32
Other	12	27	13	19

The majority of the mothers reported happiness and relief upon delivery, though the number of responses denoting these feelings was slightly less than half of the total. The multiple responses from some mothers indicated a mixture of feelings, which would be expected under the circumstances.

The mothers were asked to remember the length of time that had elapsed between delivery and the time that they had seen, held and fed the baby. More than two-thirds of the mothers (30, or 68%) had seen the baby immediately after delivery. An additional 11% had seen the baby within a few minutes, and less than half an hour, after giving birth. The remainder reported seeing the baby more than one hour after delivery, with times ranging up to two days post-partum.

By contrast, only 18% of the mothers reported that they had held their babies immediately after giving birth.

The largest number (43%) held their babies a few minutes to several hours later in the day. More than one-third of the mothers (36%) did not get to hold their babies until the day after delivery or later.

Similarly, most mothers were not able to attempt to feed their infants immediately after, or even soon after, delivery. Nine mothers (20%) first fed their babies in the recovery room; a few more (11%) fed their babies within a few hours of delivery. More than two-thirds (68%) were not able to feed their infants until the day after giving birth or even later. In the last category, maternal feeding was delayed, for some, because the infant was in the Neonatal Intensive Care Unit or because the mother was ill.

Most of the mothers in the sample (86%) had planned to breast-feed their babies, and of those, all but three were eventually able to do so. However, of the 35 mothers who did nurse their infants, most experienced delays in getting started. More than one-third (35%) were able to nurse while in the recovery room or on the same day. Again, however, the majority were not able to begin until the next day or thereafter.

When the mothers were asked whether they had had any concerns, during the time they were in the hospital, regarding mothering the baby, 28 mothers (64%) said they had not, while the remaining 36% said that they were

concerned. When asked to enumerate their concerns, however, 21 mothers (48%) responded. The most frequently cited concerns were around the anxiety/responsibility of caring for a newborn, including normal concerns of a new mother, such as feeding, bathing, and other physical care. The pain and physical discomfort following surgery was cited as a hindrance to caring for the baby. Anxiety around bonding, and lack of understanding by staff, were each mentioned by a few mothers.

Coping Physically

In contrast to the questions about concerns for the baby during the immediate post-partum period, where the majority of the mothers did not react negatively, the questions aimed at evoking specific memories of physical feelings following the surgery brought forth strong responses. The question, "How did you feel physically after the Cesarean surgery?" elicited negative responses from 93% of the mothers, such as: "Pain!!!", "terrible", "lousy", "horrible", "weak", "exhausted", "like shit".

Some mothers were more specific than others, but almost all expressed feeling physically uncomfortable at best: 21 (48%) mentioned pain (general, or in specific locations--incision, abdomen, chest, etc.); 29% were more global (terrible, horrible, miserable); 4% mentioned tiredness; the remainder were less emphatic (not great, a bit sore, not bad). Clearly, the mothers were able to

distinguish between their own physical condition and concerns relating to their infants, and were very aware of their own bodies during this period.

It was clear that, even at a distance of three months from the surgery, the mothers remembered their pain very distinctly. This is an area that most social workers might overlook, and suggests that the support group sessions need to focus on pain and pain management as a major component. A question about presence of specific physical difficulties, including types and time of occurrence, elicited affirmative responses from three-quarters of the mothers, and 86% followed by itemizing specific types and occurrences.

The most frequently mentioned physical difficulty was pain. In terms of specific difficulties, there were 48 responses, such as:

- sitting/standing/walking (21% of mothers)
- digestive problems/gas (19%)
- getting out of bed (14%)
- incision/abdominal pain (10%)
- tiredness/weakness (10%)
- fever/infection (8%)
- pain/discomfort (ribs, back, breast, or shoulder).

In addition to the presence of pain, two-thirds of the mothers also remembered those who helped them with the

physical healing process: a majority of the mothers mentioned the staff nurses as the ones who had told them how to help themselves; 20% mentioned doctors and residents; 8% mentioned private nurses; the remainder mentioned aides, roommates, the Cesarean group, etc. The specific directives mentioned by the helpers had to do with:

- getting up, walking, and moving around (most frequent)
- coughing (to clear lungs) using a pillow over abdomen
- comfortable sleeping positions
- how to get out of bed with the least effort and pain.

Apparently, many mothers felt that help was not as forthcoming, or the helpers were not as sympathetic, as they would have liked--their negative comments about help included:

- lack of staff understanding by the hospital staff of the pain following Cesarean delivery
- criticism of hospital care
- unhelpfulness of nurses
- timing of information (too late)
- limited information (baby care only)
- lack of considerateness or sympathy by nurses and doctors.

The mothers were asked what they had thought about themselves and their bodies following the Cesarean experience, with the intent of eliciting whatever issues--physical or other--the mothers might have had. In response, 82% of the mothers had specific comments about their bodies; the remaining 18% said they had felt all right. There were 65 specific responses from the mothers, of which 88% had to do with concerns about their bodies. Concerns about body outline in general, and the abdominal area in particular, accounted for 43% of the responses:

- "out of shape--am I ever going to look decent again?"
- "heavy, bloated"
- "flabby, mushy"
- "seemed...a very long time to get into any human shape"
- "a big piece of flab hanging over"
- "losing weight like crazy, but stomach still saggy".

Scar/incision/soreness issues were mentioned in 28% of the comments, such as:

- "incision tight, like a zipper--doesn't look right"
- "worried/scared about incision leaks"
- "don't like to look at or touch it"
- "still sore inside"

- "strange sight...body cut and mutilated".

The long recovery period, tiredness, the IV poles, and nonspecific comments accounted for the remainder of the responses:

- "slow recovery period--6 to 8 weeks before I felt myself"
- "couldn't do anything after I got home"
- "longer process than I thought"
- "the IV dominated the whole [hospital] stay"
- "embarrassed at having to walk with the IV pole"
- "not great"
- "not very pleased".

These findings suggest, as the nursing studies indicated, that the aftereffects of Cesarean surgery linger on, and that there is a need for discussion and support for a considerable period; hence, referral to existing post-discharge support groups, or formation of new ones, is an important adjunct to the in-hospital program.

Coping Emotionally

In addition to the focus on physical and body issues in the items above, questions were also asked which tapped the mothers' memories of their emotions. First, the mothers were asked to describe what their feelings had been right after the Cesarean surgery. There were 62 responses to this question. The most common response (13

of the mothers) was one of happiness, joy and/or elation about having a baby ("primal, deep feelings--very intense and overwhelming," "thrilled," "excited"). Relief, or a feeling of being "glad it's over with," was next in order (11 mothers). The two together account for more than two-fifths (42%) of the total responses. Nearly one-fourth of the mothers (10) reported that they didn't know, couldn't remember, or were too drugged to think anything immediately following surgery, while the next several responses dealt with being fearful/worried about the baby, disappointed, depressed, detached, tired or in pain. If these last several answers, which appear less than optimistic, are combined, they account for 37% of the total responses.

The mothers were next asked to remember and describe the feelings they had had during their hospital stay. Seventy responses were received. The most frequently mentioned feeling was that of being fine/okay/happy, which accounted for 26% of the responses (mentioned by 18 of the mothers). However, other feelings mentioned frequently, in order of appearance, included depression (12 mothers), anger/envy/frustration (10 mothers), concern/worry/fear (10 mothers), and disappointment (4 mothers), which together equal 51% of the total responses obtained. The remaining responses (wanted to go home, tired, "out of it", and other) might

be considered as neutral. Only 8 of the mothers expressed unqualified happiness or all-rightness; the rest of those giving optimistic responses tempered or contrasted them with one or more of the less positive responses listed above.

AT HOME

The mothers were asked a number of questions about the feelings and experiences they had had upon returning home from the hospital and during the first weeks following delivery, as well as about the kind and amount of help they received once at home. These questions were designed to shed some light on the emerging awareness/intermediate resolution stages of the Cesarean "trajectory of resolution".

The mothers were asked how they had felt once they got home. A total of 74 responses was obtained. Less optimistic responses such as tired (17%), depressed (12%), physically limited (9%), angry/impatient/bored (9%), overwhelmed (8%) anxious/fearful(7%), and physically in pain (3%) together accounted for 65% of the total responses; feeling good accounted for a total of 26% of the responses, while the remaining responses could not be categorized or were not pertinent. Again, only 12 of the mothers (27%) expressed unalloyed happiness/relief; most responses were mixtures ("Tired; still in pain; happy to

be home; a bit frustrated with breast-feeding...").

The mothers then were asked to tell the interviewer which of the following feelings--depression, anger, grief, guilt, confusion, memory lapses, relief, sadness, irritability, or other--described most accurately how they felt during the first few weeks after delivery. The mothers were told that they could give as many answers as they wished, and that these emotions were commonly described by Cesarean mothers during the post-partum weeks. A total of 173 responses were given.

The most frequently mentioned term was that of relief (29, or 66% of, the mothers). More than half of the mothers (59%) said that they were irritable, and large percentages of mothers also chose depression (54%), confusion (45%), and sadness (41%) as characterizing their feelings during the first post-partum weeks, followed by anger (34%), guilt (23%), memory lapses (20%), and a smaller percentage of mothers felt they had experienced grief (9%). There were also 18 responses in the "other", open-ended, category, of which the most common was fatigue, listed by 11% of the mothers, followed by frightened/overwhelmed (9%), alone/helpless (7%) and happy (7%); the remainder were scattered. This was a forced-choice item, which had been found to delineate differences among mothers in the needs-assessment study. In response to this item, 24% of the answers were more

optimistic (relief and happiness), while the remaining 76% were less optimistic. The latter figure is some 11% higher than in the immediately preceding item, where the question was open-ended.

The mothers were asked an open-ended question about the kind of help, if any, that they had gotten in order to cope with the emotional aspects of the Cesarean experience--the feelings they may have had about the surgery, themselves, and/or the baby. Thirty-five mothers answered this question directly with a "yes" or "no" and the rest went on to enumerate the kind, source and amount. Ten mothers (28% of those responding) said that they had had little or no help. Some mothers mentioned more than one source of help; two said they either didn't want or didn't need help.

Friends were listed most frequently (27% of the mothers listed them), closely followed by husbands (23%). Mothers (10%) and baby nurses (10%) were mentioned less frequently, and doctors, sisters, and the support group were mentioned occasionally (7% each). One mention was made of a therapist, one of staff nurses, and one of a mother-in-law.

The mothers were then asked more specifically about the kind of help they had received, by whom it was given, and how it was provided, as well as the amount of help in terms of time. The question did not specify

whether the "help" was emotional or instrumental, in hopes that responses would indicate both source and type of help. Many mothers mentioned more than one helper; in all, there were 151 responses to this item.

The single most frequently mentioned helper was the mother's partner, named by 54% of the mothers and accounting for 16% of the responses. Various family members were mentioned by 70% of the mothers and accounted for 20% of the responses. Friends were mentioned by 43% of the mothers (12% of total responses); nurses (baby nurse, nanny/nurse, staff nurse, pediatrician's nurse) were mentioned by 25% of the mothers, and other sources of help (doctor, support group, housekeeper, therapist, babysitter, etc) were listed by 22% of the mothers.

Regardless of the source of help, the mothers described the timing of the help as occurring primarily after they arrived home from the hospital. The proportions differed somewhat between categories of helpers, with friends providing the preponderance of their help after the mothers' arrival home (80% of responses regarding friends) and the least help while the mothers were in the hospital; partners providing 75% of their help after the arrival home; and family members providing 71% of their help during that period.

The most frequently mentioned type of help, mentioned by 77% of the mothers and accounting for 38% of

the total responses, was emotional support. This was followed by help around the house, listed by 72% of mothers and accounting for 33% of responses, and help with the baby, reported by 38% mothers and totalling 18% of the responses. Physical care of mother and/or other children was provided to 23% of the mothers, and totalled 10% of the responses. Very few mothers were able to provide an estimate as to the amount of time given by the helpers.

It appears that different helpers provided help in different ways: friends primarily provided emotional support (57% of responses regarding help from friends), family members provided household help (48%) and some baby care (34%), and partners provided both support (37%) and household help (37%).

Support Systems/Relationships

The mothers were asked a number of questions about sources of support during the entire Cesarean experience, as well as about the effect of the Cesarean on their relationships. When asked to name the most important/helpful sources of support, many mothers named more than one source; only two mothers said they had had no support; there were 77 responses in all. The person most frequently cited as the most important source of support was the partner, named by 57% of mothers. Friends were listed by 36% of the mothers as important sources of support, followed by mothers (25%), nurses/Lamaze

instructors/baby nurses (25%), and an assortment of other helpers (doctor, sister, support group, roommate, aunt), which accounted for 34% of the mothers.

The mothers were asked whether the Cesarean experience had affected their relationships with their partners and, if so, how. Apparently, in this question, the word "affected" was interpreted by the mothers to mean "negatively affected". Thus, though thirty-two of the mothers (73%) said that their relationships with their partners had not been affected by the Cesarean experience, many went on to comment that the experience had brought them closer together and/or had strengthened the relationship. Seven mothers felt that their relationships had been affected negatively--that their partners had been worried about their pain, worried about sex, unsupportive, or that they themselves had been irritable or self-conscious.

The mothers were asked whether the Cesarean experience had affected their relationships with their babies. For the vast majority of mothers (41, or 93%), the answer was an emphatic "No".

The mothers were asked whether having a Cesarean birth made them feel different from other mothers, and if so, how. Fully two-thirds of the mothers said that they did not feel different. However, 21 (48%) of the mothers responded to the second part of the question, "If so, in

what way?" with a variety of comments. Nine mothers said that they felt different, because of the method of delivery, because of observing mothers who had delivered vaginally, because of the pain, etc. Four mothers said that they were envious of other mothers who had delivered vaginally. Two mothers commented that they felt better than other mothers, or special, because of the Cesarean delivery. The remaining six mothers gave varied answers, including concern about their children, unconcern about the Cesarean because many friends had already been through the same experience, etc.

The mothers were asked whether having a Cesarean delivery had changed their views of parenthood, and if so, how. Again, a resounding majority (43, or 98%) said that their views had not changed. The one mother who said that her view of parenthood had been affected added, "Only because the Cesarean kept me from...spending time with my other child."

PERCEPTION OF SUPPORT GROUP AND SUGGESTIONS FOR THE FUTURE

A key question in the interview tapped the mothers' recollection of the Cesarean support group and asked for comments on ways the group experience might have made a difference to them. This question was designed to provide information as to the impact of the support group intervention. There were 49 responses, most of which

covered two broad topics: support/sharing, and information.

Twenty-nine mothers (66%) responded that the group had offered support and an opportunity to share their experiences with others:

- "...You could be in touch with your feelings and with other people in the same situation."

- "Everybody opened up--nobody was holding back...."

- "Made you feel you weren't the only one."

Twelve mothers (27%) thought that the group had offered helpful information about the Cesarean process:

- "It answered your questions about why the pain, why it happened, and what's on your mind."

- "It explained things the doctors didn't about what happened and why."

Five mothers (11%) commented on the quality of the group: three said simply that it was very helpful or very good; the other two said it was too small, too short, and should have been more frequent. The three remaining mothers did not remember much about the group.

Suggestions for the Future

The recollections of the support group sessions the mothers had attended dovetailed with their responses to another item, in which the mothers were asked their opinions about a number of possible ways in which the

hospital experience might be made more positive and manageable for Cesarean mothers in the future.

Thirty-four mothers (89%) thought that a support group would be helpful during the hospital stay; 21 (48%) indicated that a nurse would be a relevant provider of help; 17 (39%) thought that a doctor could provide help; 9 (20%) chose a social worker as a source of help; one mother suggested that literature about Cesareans would be helpful.

The mothers were asked why any of these sources of assistance would be helpful. Their responses had to do with support (30 mothers, or 68%) and information (23 mothers, or 52%), with two mothers proffering non-relevant answers, for a total of 55 responses. The "support" responses tended to be as follows: "To help one another, see others in the same situation, be supportive." The "information" responses were along the lines of "You should be aware and informed of what to expect." A number of mothers gave answers which combined both aspects, such as: "...You can get questions answered, talk with other women with a common experience. Because you don't think it will happen [beforehand], later you want to know as much as possible." "To answer questions. It's comforting--I'm not alone."

It will be recalled that nearly two-thirds of the mothers had stated earlier in the interview that they had

received information on Cesarean birth in their prenatal classes, and one-third had talked with their obstetricians before delivery about Cesarean birth. Within the prenatal period, the options presented to the mothers in this questionnaire item included information about Cesarean birth from obstetrician, from prepared childbirth class, and/or from any other source. Thirty-three of the mothers (75%) felt that the obstetrician should provide this information; 22 (50%) thought it should be provided in the prepared childbirth class, and one mother said that another source of information might be other mothers who had experienced Cesarean birth. The large percentage suggesting that the obstetrician provide help may reflect a perceived lack of information from that source on the mothers' part.

There were 54 responses in all as to why information during the prenatal period might be helpful: 34 of the mothers (77%) thought that it would be very important to have as much knowledge, information and/or education about Cesareans as possible beforehand, in order to "know what to expect". One mother said, "Just as you're educated about vaginal delivery, the class should include information about C-sections--anaesthesia, the incision, and recovery." Eight mothers (18%) felt that information about recovery from Cesarean ought to be included, 6 (14%) thought that emotional issues should be

discussed, 4 mothers felt that Cesarean birth should not be discussed, and two other mothers had non-relevant answers.

Of the specific choices mentioned as possibilities for post-discharge assistance, eighteen mothers (41%) indicated that the obstetrician should be available during this period; 14 (32%) felt that a support group would be helpful; 4 (9%) chose the availability of a pediatrician. Interestingly enough, under "other" possibilities, 10 mothers (23%) mentioned the availability of a telephone "hot line" to the hospital, preferably to the post-partum unit and/or support group leader(s). Additional suggestions included availability of literature, household help, husband, friends, family, and a psychiatrist "if necessary".

Additional Suggestions

The mothers were asked whether they had any additional suggestions that might help the hospital and the Social Work department in planning services for Cesarean mothers. The 52 responses that ensued covered a variety of areas, including staff attitudes, need for information, the support group, enriching the prenatal class, having Cesarean mothers room together, allowing fathers in the delivery room, and providing support.

The category receiving the most attention was that of staff issues: 15 mothers (34%) mentioned the quality

of the nursing care and/or the attitudes of nurses and doctors; 11 of the comments were critical, 3 positive, and 1 equivocal. The criticism (which could be seen as constructive) dealt with the need to heighten staff sensitivity/awareness to differences between Cesarean mothers and those who had vaginal delivery in terms of:

- length of recovery
- physical care
- information and support needed
- need for more staff to handle extra demands
- more sensitive nursing care
- more sensitive residents.

Nine mothers (20%) suggested that the hospital provide more information, whether verbal, written or audio-visual, about Cesarean delivery to mothers during their hospital stay. Seven mothers (16%) had suggestions about the Cesarean group:

- it should be offered daily
- staff should make more of an effort to inform about the group
- staff should invite mothers to participate
- husbands should be invited to attend
- a "hot line", post-discharge, for mothers to keep in touch.

SUMMARY OF FOLLOW-UP INTERVIEWS

The follow-up interview revealed that the mothers were concerned with issues of physical and emotional stress during and after their hospital stay, and with the source, type and amount of support they received in the first post-partum weeks. In contrast to the responses given by the mothers during their hospital stay, the focus in the follow-up interview shifted from physical concerns to emotional issues, with many mothers now expressing a variety of negatively charged feelings (worry, fear, anger, depression, etc.). The mothers thought that more information should be provided at all points in the pregnancy/delivery/recovery process. The Cesarean Support Group was remembered as a helpful intervention, with the support component mentioned twice as frequently as the information component in the mothers' comments.

REFERENCES

1. Information regarding length of stay, number of deliveries and number of Cesarean deliveries was obtained from the Medical Records Department of "East Side Medical Center".

CHAPTER V

SUMMARY, IMPLICATIONS AND RECOMMENDATIONS

INTRODUCTION

The Cesarean Support Group study was designed to explore and describe the effects of a new intervention, in-hospital Cesarean support groups, on participants. The intervention took place at a time when the subjects--mothers who had just delivered by Cesarean section--were dealing with the impact of major surgery, coupled with the demands of mothering an infant. For most participants, the additional stress of the role transition to new motherhood was also a factor.

EXPECTATIONS AND REALITIES

For most of the mothers in the sample, the gap between their initial expectations of childbirth and the reality of the Cesarean delivery was considerable. Ninety-three percent of the mothers in the follow-up sample had expected to deliver vaginally--89% by natural childbirth, and 4% with the help of epidural anaesthesia. A majority of the mothers reacted to the news that they were to have a Cesarean section with fear, apprehension, and anxiety.

The mothers were, for the most part, more highly educated, had higher incomes, were older, and had

higher-status jobs than the average mother in America or in New York City. However, despite these factors, and the fact that nearly all of the mothers attended prenatal classes and had regular visits with obstetricians prior to delivery, 64% indicated that they had received little or no information about Cesarean birth from their obstetricians prior to delivery. The information that had been included in the prenatal classes differed from class to class and instructor to instructor, and was often sketchy.

Because the prenatal classes stressed preparation for natural childbirth, and as a result of planning with their obstetricians to have a vaginal delivery, the vast majority of the mothers expected to have a measure of control over their bodies during the labor and delivery process. They assumed that, if they used the proper techniques of breathing and muscle control, which they and their partners had practiced, they would be able to get through the childbirth process as a team, with a minimum of anxiety and/or loss of control, and no anaesthesia. They all anticipated having their partners in the labor and delivery rooms to coach and comfort them during childbirth. Many had kept in good physical condition prior to giving birth, and expected to return to physically active lives soon afterward.

The reality was different: a sudden decision, for

80% of the mothers who reported having gotten little or no advance warning of the necessity for Cesarean surgery; exclusion of partners from the delivery room, due to hospital policy; anaesthesia; and no control over what happened to their bodies, how their bodies looked, or how long it took to regain their former physical condition. As a result, most mothers experienced feelings of disappointment, depression and failure because they could not have a vaginal delivery, shock about their body outlines and the incision, anger and deprivation about the lack of partner's presence, and exhaustion and pain from the surgery.

The mothers' normal expectation, after vaginal delivery, would have been for a hospital stay of 2 days post-partum, and a return home with some physical discomfort, but with the ability to resume normal family life and the responsibilities of caring for a newborn. The health care system is geared to such expectations--a far cry from the time, some 20 years ago, when the average stay post-partum for a vaginal delivery was 4 to 5 days. The reality for the mothers in the study sample, again dictated in part by the health-care system--this time, by DRGs which put pressure on medical facilities to limit the patient's length of stay--was an average hospital stay of 5.8 days, much longer than the current stay of mothers delivering vaginally but not really long enough to

recuperate physically from the Cesarean surgery. The hospital stay was followed by a considerable period of physical pain, discomfort and fatigue, again not expected by the mothers and often not understood by family and friends. The mothers' need was for extra help with the physical tasks of infant care and housework, and for a large measure of emotional support.

The information obtained from the mothers in the study sample indicates that at a time when mothers need additional emotional support, as well as more physical care and attention, they often get less. Most crucially, the mothers needed the presence and emotional support of their partners, who were excluded from the delivery. In addition, both mothers and partners were unprepared for the physical problems engendered by the surgery. Furthermore, nursing and medical staff were not always aware of or attentive to the special needs of Cesarean mothers. Those mothers who had a roommate who had also delivered by Cesarean reported that this was helpful, but since there was no attempt to assign mothers to rooms on the basis of Cesareans, only 7 mothers in the sample had this experience.

The lack of preparation for a process that resulted in considerable physical pain and weakness, necessitated a lengthy recovery period, and produced considerable emotional stress, points to the need for more

and better prenatal preparation for the possibility of Cesarean delivery, including the teaching of coping skills. Indeed, three-quarters of the mothers themselves were strongly in favor of having obstetricians provide this information; half suggested that it be provided in the prepared childbirth classes.

In comparing the responses of the mothers regarding source of prenatal information/education about Cesarean birth with the number of "negative" feelings (anger, depression, guilt, etc.) listed during the three-month follow-up interview, it is of particular interest that those mothers who reported receiving information on Cesarean birth only in the prenatal class also listed the fewest negative feelings of all the mothers. Given the fact that 28% of all deliveries in "East Side Medical Center", during the year the support group program took place, were by Cesarean, the mothers' expectation that this information be provided by the obstetrician and in the prenatal class was reasonable. Their own perception was that education for delivery must include all kinds of childbirth, and that mothers should know what the possibilities are and be prepared to cope with them.

PAIN

The Cesarean support group program was designed to

provide both education and emotional support. The leaders expected to encounter many questions and comments about the pain of Cesarean surgery and recovery. Pain and other varieties of physical discomfort were, indeed, major topics of concern and discussion, both in the support group sessions and in the ensuing interviews. Those mothers for whom this was the first Cesarean delivery (91% of the follow-up sample) were unprepared for the physical sequelae of abdominal surgery, including the aftereffects of anaesthesia. Their comments, even three months after delivery, reflected the strong impact of pain as well as their struggles to manage it.

Common complaints ranged from shakes, numbness, weakness, exhaustion and breathing problems--in addition to considerable pain--immediately following the surgery, to specific descriptions of source and type of pain during the hospital stay. The latter included pain in the incision, abdomen, chest, ribs, breast, and shoulder. Further descriptions of physical difficulties included sitting, standing, walking, digestive problems and gas pains, tiredness and weakness, and fever or infection. A number of mothers indicated that these physical issues continued to be of concern following their return home, and for some time thereafter.

In accordance with Nelsen's¹ formulation that education is a major component of support, the support

group sessions were designed to include a good deal of discussion of, and information about, pain and physical discomfort, in addition to suggestions for self-care.

Information about the Cesarean surgery, which included a description of the cutting and suturing processes as well as an explanation of the types of anaesthesia, provided a background for understanding the etiology of some of the pain and discomfort the mothers were experiencing.

Clearly, the support group program succeeded in its aim of providing information and education: Ninety-two per cent of the mothers reported, immediately after the support group sessions, that they had been helped by receiving specific information about pain and discomfort, and 78% of the mothers thought that the group sessions had given them the skills to cope with them. Many were able to list the specific responses and suggestions that they had found helpful.

Coping with pain and discomfort occupied a good deal of the mothers' energy. Two-thirds of the mothers in the follow-up sample noted the helpfulness of information given in the hospital. Most of the information had been offered by hospital staff, primarily by nurses but also by doctors and residents. Concrete facts--specifically about the incision, causes of gas pains, how to get out of bed with the least amount of pain, the necessity for frequent ambulation to diminish gas pains and facilitate healing,

etc.--were an important commodity, regardless of the source from which they were obtained.

Future attempts to implement a similar in-hospital program should include sensitivity to issues of pain, and emphasis on factual information. Of great importance, in planning future programs, would be a focus on providing tools--such as pain-management suggestions, and explanations of the sources and causes of physical discomfort--to enable Cesarean mothers to cope with pain that is often more severe, difficult, and unexpected than anything they have previously experienced.

Much of the expertise in providing physical care, knowledge of surgical procedures, and suggestions for pain management and self-care was the province of the nurses, some of whom co-lead the support groups. Many mothers thought that nursing and medical staff needed to become more aware of differences between Cesarean-delivered and vaginally-delivered mothers in terms of length of recovery, physical care, and type of information needed. It was suggested that much more information be provided to mothers in the hospital; a majority of them thought that this could be done by means of the support group. Others thought that information could also be conveyed through literature, audio-visual material, or other means. Involvement of nursing staff in the support groups, which proved helpful during the study, as well as in-service

education of nurses about the importance of combined education and emotional support, could also help nursing staff become more aware of the special needs of Cesarean mothers.

EMOTIONS

Just as the mothers were unprepared for the physical sequelae of Cesarean surgery, so were they unaware of the psychological effects related to Cesarean birth. The absence of their partner from the delivery process, the long hospital stay, the need to focus on their own needs at the same time that they felt they should be emotionally connecting with their newborn, the increased need for support, and the lack of understanding of their condition and of the implications of Cesarean delivery for the recovery process, all contributed to their feelings of confusion, surprise, and anxiety.

Even before the birth, the majority of mothers were apprehensive and fearful about the prospect of Cesarean surgery. The actual event led them, immediately after delivery and during their hospital stay, to experience a mixture of feelings. The most commonly expressed feelings were happiness and relief at having a healthy infant. However, very few mothers expressed unqualified happiness. Seventy percent of the mothers mentioned disappointment and frustration about not having

the kind of birth experience they had planned for, shock and worry about their physical condition, disorientation and feeling "out of it" because of the medications and anaesthesia utilized in the surgical and recuperation processes, and/or depression and detachment which left them wondering whether they could "bond" with their baby.

The support group program provided both information about emotions common to Cesarean mothers, and an opportunity for the mothers to express and share their own feelings about the Cesarean birth and recovery processes. In this respect, as with respect to pain issues, the group achieved its aim: 78% of the mothers in the support groups rated the group as being successful in increasing their knowledge and understanding of the emotional stressors. Three-quarters of the mothers were able to enumerate what they had learned. Their responses ranged from concrete items, such as mood swings, to understanding the commonality of such feelings as disappointment and shock. In addition to providing information, the group also enabled the mothers to think that they had the resources to cope with emotional stresses. Two-thirds of the mothers rated the group as helpful in this respect. Many mothers were able to list specific coping skills they had learned, such as talking about feelings and asking for help; more importantly, they had become aware of the importance of social support

in dealing with the normal emotional stressors of Cesarean birth.

Despite the help they received from the support group while they were in the hospital, the mothers continued to experience a diversity of emotions after they returned home. Most mothers in the follow-up sample mentioned more than one feeling, and emotions such as depression, anger and anxiety accounted for two-thirds of the total responses reported by the mothers. Again, only a small number of mothers expressed unalloyed happiness or relief. When the mothers were presented with a more probing item, a forced-choice list of feelings commonly described by Cesarean mothers during the post-partum weeks, three-fourths of their total responses were in the "less optimistic" category. This may indicate that Cesarean mothers feel they need to keep their less positive emotions (irritability, sadness, guilt, anger, etc.) under wraps in the face of the expectation that new mothers should be happy and positive.

Of special interest is the finding that even those mothers who reported, in the follow-up interview, that they had received help (from partner, friend, relative, etc.) in dealing with the emotional aspects of the Cesarean experience during and after the hospital stay listed a mean of 3.0 negative, or "less optimistic", feelings on the forced-choice item. This suggests that,

while the support group and other in-hospital efforts may indeed assist the mothers to cope with their immediate emotions, the mothers' network of family and friends constitutes an important source of ongoing help as the mothers leave the hospital and begin the tasks associated with infant care and return to household, family and employment.

Future program efforts should be directed toward enabling the mothers to express the full range of their feelings, while reassuring them that such feelings are common to Cesarean mothers and are normal under the circumstances. In addition, educating the mothers about obtaining ongoing social and emotional support, an important coping tool which helps alleviate emotional stressors, should be emphasized.

SUPPORT: PARTNERS, FAMILY, FRIENDS AND GROUP

Emotional support figured prominently in the mothers' recuperation process. They remembered in detail the sources and types of support provided during the delivery process, while in the hospital, and after the return home. Because of the unexpected nature of the Cesarean delivery, the mothers needed additional emotional support during the actual birth process. Many mothers expressed feelings of disappointment and deprivation because their partners could not witness the birth or be

with them. They were sensitive to the efforts of medical and nursing staff to be supportive, and mentioned specific individuals, such as Labor and Delivery nurses, anaesthesiologists and obstetricians, as being helpful by explaining procedures, providing reassurance, joking, holding their hands, etc.

The mothers' need for emotional and social support was evident during the hospital stay, as demonstrated in their participation in the support group sessions. They discussed their experiences not only with the professionals who were the group co-leaders, but with the other participants, and were reassured to find that others shared common emotions, concerns, and physical difficulties. Their response to the group's provision of support was the most positive of any item on the group feedback form: when asked how useful it was to meet with others in the same situation, 100% of the mothers rated this as helpful. Even three months after leaving the hospital, two-thirds of the mothers in the follow-up sample described specific ways in which the group had offered support: an opportunity to be in touch with one's feelings and with others in the same situation, a chance to be open, and not to have to hold back emotions, and a realization that one was not alone or different. When asked for suggestions for helping future Cesarean mothers, 89% included an in-hospital support group, while nurses,

doctors and social workers were mentioned much less frequently as potential sources of help. More mothers mentioned support, as a specific component of the "help" to be offered, than any other item.

In spite of recognizing and valuing the support provided in the hospital by the group, the mothers tended to think of other sources of "help", and of the help occurring primarily after their discharge from the hospital, as important in coping with the emotional aspects of Cesarean birth. Of the mothers in the follow-up sample, most listed partners as the most important and most frequent source of help. Friends were also mentioned as important and frequent sources of help. Many in the follow-up sample mentioned mothers, sisters, and baby nurses. Very few mentioned doctors or the support group. Regardless of the source of the assistance, the great majority of it was perceived as being provided after the return home.

Of particular interest is the fact that the most frequently mentioned type of help was emotional support, listed by more than three-fourths of the mothers. This was followed by such concrete items as housework, baby care, and physical care of mother and/or other children. Friends were cited as having provided mainly emotional support, partners as providing both emotional support and concrete help, and family members as providing household

help and baby care. The mothers were not prompted by the interviewer or by having a forced-choice item regarding emotional support; the answers were spontaneous. It is possible that, because the support group sessions strongly emphasized obtaining emotional support after the return home, the mothers were especially aware of its importance, sought it directly from partners and friends, and tended to express more negative feelings if they did not get it.

Although suggestions for post-discharge help did not feature a support group as prominently as had suggestions for in-hospital help, one-third of the mothers requested such a group, and one-quarter of the mothers asked for a telephone "hot line" to the support group leaders. Clearly, despite the sources and types of help described as part of the natural social network of the mothers in the study, a sizeable number of mothers thought additional help should be available.

Future program efforts should emphasize increasing mothers' awareness of their natural support networks, and provide skills for mobilizing these networks as well as suggestions for supplementing them (with household help, baby nurses, etc.) where indicated. Further efforts should be made to provide a connection between the hospital and the home, whether by way of an ongoing outpatient support group, a telephone link with the support-group leaders, or a designated staff member to

take telephone calls from mothers who have questions or issues to discuss after they return home. Opportunities to educate nursing and medical staff as to the importance of support for Cesarean mothers also should not be overlooked.

THE FAMILY: PARTNER AND BABY

Fathers

All of the participants in the support group program, including the unmarried mothers, implied that their partners were actively involved in relationships with them. (This may indicate an important difference between the sample in the study and many mothers today.) Though the mothers' partners were, on the whole, more highly educated and employed at higher-level jobs than the average American, and though most partners had both attended the prenatal classes and expected to participate actively in the birth process, the partners were no more prepared to deal with the exigencies of Cesarean birth than were the mothers. The prenatal education had not sensitized the partners to the special needs of Cesarean mothers: the issue of pain, the typical emotions experienced during and after Cesarean delivery, and the consequent importance of support.

The mothers all commented, during the support group sessions, on the difficulties posed by the

hospital's policy of not allowing fathers in the delivery room during Cesarean birth. They felt deprived of their most important source of support. Since most of the mothers had expected their partners to coach them and to be available throughout the birth process, they may have felt even more keenly the sudden loss of their partners' presence during such a stressful time. The mothers strongly recommended that the hospital's policy be changed to meet the needs of mothers, rather than reflect what they perceived to be the issue of convenience to medical staff.

The mothers in the follow-up sample did not offer comments about their partners' role during their hospital stay, except to indicate that the majority of the help they received from partners occurred after the return home. This may imply that either the partners' help was not needed in the hospital, or that the partners did not offer it there as much as at home.

The mothers were clear, however, that their partners were their most important source of help and support, not only after the return home, but during the entire Cesarean experience. Three-quarters of the mothers said that their relationships with their partners had not been adversely affected by the Cesarean; indeed, many stated that the experience had brought them closer together.

Future planning for support group content should include a focus on ways in which partners can enhance mothers' coping: types of help and support they can offer, when help is needed most, etc. In this way, mothers may be able to educate their partners, as well as to believe that their requests and needs for help and support are normal. Written literature in the form of handouts should be available to partners as well as to mothers. Thought should also be given to the issue of inviting fathers to sit in on support group sessions: they could observe and listen to mothers' issues, and their sensitivity to their partners' physical condition and to the importance of support could be heightened; on the other hand, their presence might be perceived as intrusive or be a hindrance to mothers' open discussion of feelings.

Infants

Despite the fact that the nursing studies had raised the possibility that Cesarean delivery might interfere with the mother-infant bonding process, the mothers in the support group indicated that their own bonding with their infants had not been affected. A majority of the mothers in the follow-up sample stated that they had been apprehensive, and concerned about their babies' well-being, upon learning that they would deliver by Cesarean, and about one-third of the mothers reported

feeling worried about and/or detached from their infants immediately after delivery. However, most mothers stated that they felt happy and relieved immediately after the birth.

Nearly four-fifths of the mothers were able to see their infants immediately or within a few minutes of delivery. (One-fifth of the mothers had had general anaesthesia, and were not conscious at the time of delivery.) The sight of their infants may have been of major importance in reassuring the mothers as to the babies' condition at that point in time.

By contrast, only one-fourth of the mothers held their babies immediately after or within a few minutes of delivery, and more than one-third did not hold their babies until the day after they were born, or even later. Similarly, less than one-third of the mothers were able to feed their babies within the first few hours after delivery; the majority could not feed their infants until the next day, or even thereafter. The mothers who had planned to breast-feed experienced delays in getting started, although almost all of them eventually succeeded in nursing their infants.

The delays in holding and feeding did not appear to affect the mothers' relationships with their babies, however: nearly two-thirds of the mothers stated that they did not have concerns about mothering the baby during

their hospital stay. The most frequently mentioned concerns of the remaining mothers had to do with issues of caring for a newborn, feeding, bathing, and other normal concerns of a new mother not related to the Cesarean, though a few mothers cited the pain and discomfort following the surgery as a hindrance to caring for the baby. At three months post-partum, 93% of the mothers stated that the Cesarean experience had not affected their relationships with their babies, and 98% of the mothers said that having a Cesarean delivery had not changed their views of parenthood.

The analysis of data from the investigator's previous needs assessment study had suggested that mothers who believed that the Cesarean delivery had been performed because of a problem the baby was having (fetal distress, breech, etc.) tended to have different responses to a number of items--including bonding, emotional coping, and physical reactions--than mothers who thought that the Cesarean had taken place because of a problem of their own. Further, mothers who reported receiving information/emotional support reported fewer negative emotions during the first weeks after delivery than those who did not. However, the sample of mothers in the needs-assessment study was quite small, and it was thought that a larger sample might yield more information as to whether indeed the mothers' perceptions affected their

responses. If so, future support group efforts might utilize this information in planning content.

With this in mind, the data from the feedback interviews and the follow-up interviews in the support group program were examined and a number of comparisons were made.

1. The "baby-problem" group (those mothers who perceived the Cesarean delivery as having been necessitated by some problem of the infant's, or 55% of the total in the follow-up sample) reported more negative feelings (concern, apprehension) about their babies (42% of the mothers) than did the "mother-problem" group (25%).

2. The "baby-problem" group also reported feeling considerably more different from other, vaginally-delivered, mothers (50%) than the "mother-problem" group (15%).

3. The "baby-problem" group was somewhat more likely (92%) to suggest an in-hospital support group for future Cesarean mothers than was the "mother-problem" group (85%).

4. The "baby-problem" group was less likely (21%) to suggest a post-discharge support group for future mothers than the mother-problem group (35%), but more of the "baby-problem" mothers (33%) advocated the establishment of a "hot-line" or telephone link to the post-partum unit or support group leaders than did the

"mother-problem" group (10%).

5. There was little or no difference between the "baby-problem" and "mother-problem" groups on the issues of concerns about mothering babies, views of parenthood, or reports of physical reactions/concerns during the Cesarean birth and recovery.

6. Those "baby-problem" mothers who reported receiving help in coping with the emotional aspects of Cesarean birth (83% of the group) listed a mean of 3.4 negative feelings (anger, depression, etc.), while the "mother-problem" mothers who received help in coping (70%) reported a mean of 2.9 negative feelings.

The above information implies that there may be different constituencies within the population of Cesarean mothers, and that information and emotional support appropriate to the needs of each group must be included when planning services for future Cesarean support programs. It is possible that the "baby-problem" group got more support because of the perception that the baby was in jeopardy; perhaps the mothers felt more entitled to ask for help because of this, or they felt worse because of their worry and anxiety and so behaved in such a way as to get more help. Perhaps those in the "mother-problem" group felt guilty or at fault for having had a Cesarean, felt they should focus on their babies, and were less likely to call attention to their own needs.

Content of the in-hospital support groups should include reassurance that the Cesarean surgery, in and of itself, does not adversely affect babies' growth and development, and leaders should encourage mothers to voice their concerns about their babies' conditions to their pediatricians so as to obtain accurate information/direct reassurance on this issue. Mothers who perceive the Cesarean surgery as having been performed due to a problem on their part need to be reassured that their needs and feelings are important, and that asking for (and receiving) help for their own physical and emotional needs is legitimate. Further, future program development efforts should consider the provision of both post-discharge support groups and a telephone link to the support-group leaders.

SYSTEMIC FACTORS

In reviewing the development, progress and ending of the Cesarean support group program, the importance of institutional support, at all levels, appeared to be critical. The investigator was a guest of the Social Work department in a system where the Social Work department itself was dependent on the host institution and, as suspected, had limited power or recognition. Further, the presence of social work as a discipline--as personified by the staff social worker assigned to the Post-partum Unit,

where the support groups took place--was a "sometime thing", and neither the Patient Care Coordinator on the unit nor the staff nurses were accustomed to working closely with social workers. In addition, the only groups or classes that existed on the unit, up to the time of the study, were educational and were run by the staff nurses, while the Cesarean groups were geared toward support as well as education and were co-led by a social worker and a Nurse Educator. Issues of a systemic nature were raised at all points in the process:

1. The investigator might have had an easier or quicker time of it if a different site--one at which the investigator was a staff member, rather than an outsider--had been chosen.

2. The approval process might have been speedier had the Social Work department been more visible within the hospital hierarchy, and/or had there been more of a history of collaboration between Social Work and Nursing at the administrative level.

3. There might have been more acceptance at the unit level, initially, had the OB social worker been more involved with the day-to-day workings of the unit, or had there been previous interdisciplinary collaboration there.

4. The PCC and staff nurses might have been more enthusiastic at first if the Nurse Educator had not volunteered to co-lead the support groups, and/or if the

culture of the unit had not been as conservative and cautious as it was.

5. The group might have continued if a regular staff member, rather than a student nearing the end of placement, had been assigned as co-leader.

6. Since the investigator had revised the handout on Cesarean birth, together with the Nurse Educator co-leader, the way could have remained open for reinstating interdisciplinary collaboration on the Post-partum unit and perhaps reviving the groups.

7. The visit from the Public Relations staff person, who sat in on a group session, could have been exploited--or at least followed up--by the Social Work department. After all, there must have been some way in which a new program, never before tried in any hospital and so well-received by the patients, could have been publicized to the hospital's, and thus to the Social Work department's, advantage.²

The support group participants had many concerns about the system in which they had chosen to give birth, as well as numerous suggestions for improving it at all levels (hospital policies, unit and staff issues, and the support group itself). These were included in both the immediate feedback and follow-up interviews. The single most important issue was the hospital's policy of not allowing fathers into the delivery room for Cesarean

delivery, the rationale for which has been discussed above. Almost every mother commented adversely on this policy, and many felt that they would not recommend the hospital to friends and family unless it were changed. (In this age of increased competition for business among health care facilities, the hospital administration would do well to reassess policies of this type.) Other criticism was leveled at the physical conditions (dirty rooms, not enough housekeeping help, shortage of nurses, lack of private rooms for Cesarean mothers), nursing and medical staff (poor nursing care, insensitive residents, lack of knowledge on staff's part of the needs of Cesarean mothers), and the lack of information as to how things worked on the unit (times for visiting hours, meals, nursery visits, babies in rooms, classes, etc.). For vaginally-delivered mothers, who tend to spend only two days in the hospital, these issues may have been relatively less important than they were to the Cesarean mothers.

The suggestions and criticisms about the support group program itself also included systemic issues: that the groups be better-publicized, take place at a time convenient to the mothers, and meet more frequently. In addition, suggestions were made that staff should make more of an effort to inform mothers and invite them to participate; that more informational material, in the

form of written handouts (such as the revised and expanded handout on Cesaran birth) or audio-visual presentations, be provided to Cesarean mothers; and that a telephone link be available after discharge so mothers could keep in touch.

Future attempts to institute a Cesarean support group program should take institutional factors into account. Such issues as learning how a given system works and the place of social work within it, facilitating the approval process at the administrative level, legitimation of the group leader--and of social work as a discipline--at the unit level, choice and preparation of co-leader(s), publicizing the program within the unit and within the larger system, etc., must be as carefully considered as the target population and content of sessions. The opinions of the group participants--the consumers--must also be considered, and a feedback-cycle mechanism for monitoring suggestions and criticism, such as a group evaluation sheet, should be built into the program.

CONCLUSION AND IMPLICATIONS FOR SOCIAL WORK PRACTICE

The Cesarean support group program attempted to develop a social work intervention which would occur at a critical point in Cesarean mothers' resolution of the Cesarean birth process. The aim of the program was to

facilitate emotional and physical healing at a time when the mothers are in the earliest, most difficult stages of the process. In designing the format and content of the support group sessions, the investigator identified the principal physical and emotional stressors, developed strategies to disseminate information about stress prevention and coping, and included material which would help the mothers to plan for their future needs.³

With systemic issues in mind, the investigator attempted to implement the program within a highly complex institution in which social work as a discipline, and the social work department, had a relatively limited impact. Despite the success of the program, as rated by the participants and as eventually recognized by the nursing staff, systemic issues and delays in beginning the support groups contributed to the fact that the program did not continue after the investigator left the institution.

However, a number of implications can be drawn that may be of use in future clinical social work planning of similar groups. First, an assessment of the structure within which the program is to be offered is essential. Barriers to approval and/or legitimation of the program or the group leader(s) must be anticipated and negotiated. Factors within the system that may affect attendance or participation in the program need to be identified and dealt with.

Second, the sample in the support group program was certainly not reflective of the "average" Cesarean mother in terms of income, education, age, ethnicity or marital status. These relatively affluent, relatively well-educated, relatively mature and sophisticated mothers, almost all of whom had regular prenatal visits with an obstetrician and most of whom participated in prenatal classes with their partners, reported receiving not enough prenatal information about Cesarean birth, insufficient attention by nursing and medical staff to the needs of Cesarean mothers, and need for additional emotional support after the return home. What, then, must be true of the economically disadvantaged ethnic groups, less-educated, younger, less-sophisticated, unmarried mothers, those with little or no prenatal care or education? Surely the results of this study imply that a program which provides continuity of care, including prenatal information about Cesarean birth, in-hospital support groups, and a post-discharge link to the hospital in the form of an aftercare group and/or a telephone connection, could provide a portion of the support and education that mothers need in order to resolve the Cesarean birth process in a positive manner. Social workers with good clinical skills need to be included at all phases of such a program--in identifying mothers in need of prenatal services, in education and staff

development of those providing the prenatal information, in the in-hospital groups both as teachers of potential nursing and social work staff co-leaders and as cooperating members of an interdisciplinary support-group team, and as leaders and telephone-support personnel for the aftercare component. This is consistent with the client- and family-centered approaches valued by both social work and nursing, in perinatal care as well as in other aspects of health care.

Third, because of social workers' unique focus on person-in-environment, they are in a position to be especially aware of the need for support. A more specific emphasis on the importance of, and the normal need for, emotional support by Cesarean mothers, as well as the techniques for obtaining support, needs to be built into the content of the group sessions. An understanding of the important part played by providing information in the support process will lead to the inclusion of more pertinent content on pain and pain management as well. Reassurance that both physical pain and emotions such as sadness, anger and guilt are normal sequelae of Cesarean birth, and encouragement of mothers to let their physical and emotional needs be known by their natural support networks of friends and family, need to be supplemented by concrete suggestions and referrals for help that family and friends may not be able to supply, in terms of

homemakers or baby-care personnel.

The opportunity for providing services to Cesarean mothers in the form of support groups may not exist in some hospitals, whether due to shortage of staff, to institutional denial of Cesarean mothers as a special group, to lack of facilities for group meetings, or to other reasons. For those social workers who are not involved with the planning or provision of support groups but who are working with Cesarean-delivered mothers, the issues of mothers' emotional reactions and of pain management, as well as the other points mentioned above, are important to keep in mind. Further, opportunities to institutionalize Cesarean birth as an alternative method of delivery, rather than as a deviant one, can arise at any point in the pregnancy/delivery/aftercare process, and do not have to be confined to the support group arena. Collaboration with nurses, in terms of both learning more about the actual delivery and recovery processes and imparting information about mothers' feelings, can take place informally. More can be learned about the specific types of pain and how to help mothers to alleviate pain; more can be done to explain the reasons for pain; more can be discovered about the meaning of pain to each individual. In the same way, mothers' emotions can be discussed individually, within a framework of normative reactions for the Cesarean experience, rather than

dismissed as mere complaints or viewed with alarm. Education for social work in health care should promote awareness of both the physical and the psychological factors pertinent to this population so that service providers would be prepared to understand Cesarean mothers' unique needs and to facilitate the resolution of the Cesarean birth experience.

In the planning, implementation and evaluation of the Cesarean support group program, knowledge both of systems and of the needs of the target population were essential to success. Future efforts to develop programs for Cesarean mothers, a growing patient population in hospitals across the country, need to take into account issues of continuity of care and the provision of in-hospital support as important aspects of such programs.

REFERENCES

1. Judith C. Nelsen, "Support: A Necessary Condition for Change," Social Work (September 1980): 388-92.
2. Bruce S. Jansson and June Simmons, "Building Departmental or Unit Power Within Human Service Organizations: Empirical Findings and Theory Building," Administration in Social Work 8 (Fall 1984): 41-56.
3. Hal S. Kopeikin, Valerie Marshall and Michael J. Goldstein, "Stages and Impact of Crisis-Oriented Family Therapy in the Aftercare of Acute Schizophrenia," Family Therapy in Schizophrenia, ed. William R. McFarlane, New York: Guilford Press, 1983.

APPENDIX I

NEEDS-ASSESSMENT STUDY INTERVIEW

Background Information

1. a. Age__
2. Education--highest grade completed__
3. Work--current?_____
- previous?_____
4. Marital status _____
5. If married, how long?_____
6. Husband's work_____
7. Number of children____ Ages_____
8. Cesarean birth(s): when?_____
9. Vaginal birth(s): when?_____
10. Did your mother or another family member have a
Cesarean?
Yes__ No__ Who_____

Birth Plan and Preparation

11. Original birth plans:
 - a. natural Yes__ No__ other (anaesthesia, spinal,
etc.)__
 - b. Hospital Yes__ No__ other (birthing center,
etc.)__
12. Did you attend prenatal/childbirth class(es)? Yes__
No__

a. If so, did they provide any information about Cesarean birth?

Yes__ No__

b. Did your doctor discuss Cesarean birth with you?
Yes__ No__

c. Did you talk with anyone else about it? Yes__ No__

13. What was the reason for your having a Cesarean?

14. How much preparation time before you had the Cesarean?

a. (none to 1/2 hour=)emergency__

b. (1-3 hours=)informed during labor__

c. (more than one day=)scheduled__

15. Can you remember your reaction when you learned you would have a Cesarean?

Actual Birth Experience

16. Type of anaesthesia: general__ local__
other_____

17. Was husband present? Yes__ No__

18. If No, why not?

19. Any complications? Yes__ No__ If yes, describe.

Post-partum--Bonding

20. What feelings did you have about the baby?

21. How long before you:

a. saw the baby?_____

b. held the baby?_____

c. fed the baby?_____

d. nursed the baby (if breast feeding)?_____

22. Did you have concerns about mothering the baby?

Coping Emotionally

23. What feelings did you have right after the Cesarean delivery?

24. What feelings did you have during hospitalization?

25. What feelings did you have once you got home?

26. Which term(s) describe most accurately your feelings during the first weeks following delivery?

- a. depression__ b. anger__ c. grief__ d. guilt__
- e. confusion__ f. memory lapses__ g. relief__
- h. other_____

27. What help did you get in order to cope with the emotional aspects of this experience?

28. From whom did you get the help?

- a. friends__ b. family__ c. doctor__ d. nurse__
- e. social worker__ f. support group__ g. other__

29. When did you get this help?

Coping Physically

30. How did you feel physically after the Cesarean surgery?

31. Did you have any physical difficulties? Yes__ No__ If so, when?

32. Did anyone tell you how to help yourself with the physical healing process? Yes__ No__ If so, who and when?

33. How did you feel about yourself--your body--following this Cesarean experience?

Support Systems/Interventions

34. When you think about the total Cesarean experience, what sources of support were most helpful/important for you?

35. Did this experience affect your relationship with your husband? How?

36. Did this experience affect your relationship with your baby? How?

37. Has having a Cesarean birth made you feel different from other mothers? If so, in what way?

38. Has having a Cesarean birth changed your view of parenthood?

39. What would you suggest for future Cesarean mothers to make their experiences more positive and manageable?

Choose as many as you like:

a. Pre-natal information about Cesarean birth through

(1) obstetrician___ (2) prepared childbirth class___ (3) other___

Why do you think this would be helpful?

b. During hospital stay: information/support from:

(1) doctor___ (2) nurse___ (3) social worker___
(4) a support group___ (5) other___

Why would this be helpful?

c. Following discharge: availability of

(1) obstetrician___ (2) pediatrician___ (3) support group___ (4) other___

How would this be helpful?

40. If a support group had been available, would you have participated? Yes___ No___

(If yes) At what point do you think it would have been most helpful?

APPENDIX II
CESAREAN SUPPORT GROUP PROGRAM
PARTICIPANT EVALUATION FORM

1a. How much do you think the group increased your knowledge and understanding about the Cesarean birth process?

Not at all__ Very little__ Somewhat__ Quite a bit__ Very much__

1b. If you learned something about the Cesarean birth process, what was it?

2a. How much do you think the group increased your knowledge and understanding about the physical stresses often experienced in the first few days after Cesarean delivery?

Not at all__ Very little__ Somewhat__ Quite a bit__ Very much__

2b. If you learned something about the physical stresses, what was it?

3a. How much do you think the group increased your knowledge and understanding of the emotional stresses often experienced in the first few days after Cesarean delivery?

Not at all__ Very little__ Somewhat__ Quite a bit__ Very much__

3b. If you learned something about the emotional stresses, what was it?

4a. How much did the group help you to think that you can do something to deal with the physical stresses?

Not at all__ Very little__ Somewhat__ Quite a bit__ Very much__

4b. How can you now deal with these?

5a. How much did the group help you to think that you can do something to deal with the emotional stresses?

Not at all__ Very little__ Somewhat__ Quite a bit__ Very much__

5b. How can you now deal with these?

6. How useful do you think it is for Cesarean mothers to meet with others in the same situation ?

Not at all__ Very little__ Somewhat__ Quite a bit__ Very much__

7. What did you like best about the group? Please explain.

8. What did you like least about the group? Please explain.

9. Would you make any changes in this group for the future, regarding:

Yes No What

a. number of sessions

b. length of sessions

c. material that was covered

- d. sequence of material
 - e. format
 - f. leader(s)
 - g. participants (#, selection, etc.)
 - h. arrangements (time, location, etc.)
 - i. other
10. Any additional comments about the program?

APPENDIX III
CESAREAN QUESTIONNAIRE

Background Information

1. a. Age__ b. Ethnicity__ c. Priv/Clin__ d. LOS__
2. Education--highest grade completed__
3. Work--current?_____
- previous?_____
4. Marital status_____
5. If married, how long?_____
6. Partner's work_____ Age__ Educ._____
- Ethn.____
7. Number of children__ Ages_____
8. Cesarean birth(s): when?_____
9. Vaginal birth(s): when?_____
10. Did your mother or another family member have a
Cesarean?
Yes__ No__ Who_____

Birth Plan and Preparation

11. Original birth plans:
 - a. natural Yes__ No__ other (anaesthesia, spinal,
etc.)_____
 - b. Hospital Yes__ No__ other (birthing center,
etc.)_____
12. Did you attend prenatal/childbirth class(es)? Yes__
No__ w/partner?
 - a. If so, did they provide any information about

Cesarean birth?

Yes__ No__ Can you remember what it was, how long they spent, what was covered?

b. Did your doctor discuss Cesarean birth with you?
Yes__ No__

c. Did you talk with anyone else about it? Yes__ No__
13. [Actual reason for Cesarean, from face sheet:_____]

Why do you think you had to have a Cesarean?
14. How long before you had the Cesarean were you aware it was going to take place?

a. (none to 1/2 hour=)emergency__
b. (1-3 hours=)informed during labor__
c. (more than one day=)scheduled__

15. Can you remember and describe what your reaction was when you learned you would have a Cesarean?

Actual Birth Experience

16. Type of anaesthesia: general__ local__
other_____

17. Was partner present during delivery? Yes__ No__

18. If you can remember how you felt immediately after the Cesarean, would you please describe it?

IMMEDIATE POST-PARTUM PERIOD

Bonding

19. What thoughts and/or feelings did you have about the baby?

20. How long before you:

- a. saw the baby?_____
 - b. held the baby?_____
 - c. fed the baby?_____
 - d. nursed the baby (if breast feeding)?_____
21. Did you have concerns about mothering the baby?
Yes___ No___

If so, what were they?

Coping Physically

22. How did you feel physically after the Cesarean surgery?
23. Did you have any physical difficulties? Yes___ No___ If so, what and when?
24. Did anyone tell you how to help yourself with the physical healing process? Yes___ No___ If so, who and when?
25. What did you think about yourself--your body--following this Cesarean experience?

Coping Emotionally

26. What feelings did you have right after the Cesarean delivery?
27. How did you feel during the time you were in the hospital?
28. How did you feel once you got home?
29. Which term(s) describe most accurately your feelings during the first weeks following delivery?
- a. depression___ b. anger___ c. grief___ d. guilt___
 - e. confusion___ f. memory lapses___ g. relief___

h. sadness__ i. irritability__ j. other_____

Perceptions Regarding Help

30. What kind of help, if any, did you get in order to cope with the emotional aspects of this experience? (That is, the feelings and concerns you may have had about the surgery, yourself, the baby?)

31. "Perceived Help" chart by 1) source of help; 2) timing; 3) type; 4) amount of time spent:

<u>Who</u>	<u>When</u>	<u>How</u>	<u>Time</u>
------------	-------------	------------	-------------

a. partner

b. family:_____

c. friends

d. doctor

e. nurse

f. social wkr

g. supp. grp.

h. other

Support Systems/Interventions

32. When you think about the total Cesarean experience, what sources of support were most helpful/important for you? a. _____ b. _____

33. Did this experience affect your relationship with your partner? Yes__ No__ How?

34. Did this experience affect your relationship with your baby? Yes__ No__ How?

35. Has having a Cesarean birth made you feel different from other mothers? Yes__ No__ If so, in what way?

36. Has having a Cesarean birth changed your view of parenthood? Yes__ No__ How?

37. What would you suggest for future Cesarean mothers to make their experiences more positive and manageable?

Choose as many as you like:

a. Pre-natal information about Cesarean birth through

(1) obstetrician__ (2) prepared childbirth class__ (3) other__

Why do you think this would be helpful?

b. During hospital stay: information/support from:

(1) doctor__ (2) nurse__ (3) social worker__
(4) a support group__ (5) other__

Why would this be helpful?

c. Following discharge: availability of

(1) obstetrician__ (2) pediatrician__ (3) support group__ (4) other__

How would this be helpful?

38. Is there anything additional you would like to add that might be helpful to the hospital and the Social Work Department in planning services for Cesarean mothers?

[The following question is to be used only for participants in the Cesarean Support Group.]

39. Do you remember/recall the Cesarean group and any ways in which it may have made a difference?

[The following questions are to be used for those women who are being surveyed before the implementation of the support group intervention.]

40. If a support group had been available, would you have participated?

Yes ___ No ___

41. If yes, at which point do you think it would have been most helpful?

42. What would you have liked it to cover/include?

BIBLIOGRAPHY

- Abramson, Julie. "A Non-Client-Centered Approach to Program Development in a Medical Setting." In Agency-Based Social Work, pp. 178-186. Edited by Harold Weissman, Irwin Epstein and Andrea Savage. Philadelphia: Temple University Press, 1983.
- Affonso, Dyanne D. and Stichler, Jaynelle F. "Cesarean Birth: Women's Reactions." American Journal of Nursing (March 1980): 468-470.
- Anderson, Carol M.; Hogarty, Gerard E.; and Reiss, Douglass J. "Family Treatment of Adult Schizophrenic Patients: A Psycho-Educational Approach." Schizophrenia Bulletin 6 (1980): 99-115.
- Bernard, Sydney E. "Why Service Delivery Programs Fail." Social Work May 1975: 206-210.
- Berry, Kathy Higgins. "The Body Image of a Primigravida Following Cesarean Delivery." Issues in Health Care of Women 6: 367-76.
- Bracht, Neil F. "Preparing New Generations of Social Workers for Practice in Health Settings." Social Work in Health Care 8 (Spring 1983): 29-43.
- Bradley, Christine F.; Ross, Susan E.; and Warnyca, Jennifer. "A Prospective Study of Mothers' Attitudes and Feelings Following Cesarean and Vaginal Births." Birth 10 (Summer 1983): 79-83.
- Brazelton, T. Berry. On Becoming a Family. New York: Delacorte Press/Seymour Lawrence, 1981.
- Caputi, Marie A. "A 'Quality of Life' Model for Social Work Practice in Health Care." Health and Social Work 7 (May 1982): 103-110.
- Cox, Bonnie E. and Smith, Elaine C. "The Mother's Self-Esteem After a Cesarean Delivery." American Journal of Maternal Child Nursing 7 (September/October 1982): 309-14.
- Cranley, Mecca S.; Hedahl, Kathleen J.; and Pegg, Susan H. "Women's Perceptions of Vaginal and Cesarean Deliveries." Nursing Research 32 (Jan-Feb 1983): 10-15.

- Dana, Bess; Banta, H. David; and Deuschle, Kurt W. "An Agenda for the Future of Interprofessionalism." In Medicine and Social Work, pp. 77-88. Edited by Helen Rehr. New York: Prodist, 1974.
- Davidson, Kay W. "Development of a Support Program for Social Workers Serving Cancer Patients." D.S.W. dissertation, City University of New York, 1983.
- Davies, Karlene. "A Conflict of Roles." Nursing Mirror (July 7, 1982): iii-iv.
- Dillon, Carolyn. "Families, Transitions, and Health: Another Look." Social Work in Health Care 10 (Summer 1985): 35-44.
- "Doctors Debate Surgery's Place in the Maternity Ward." New York Times, 24 March 1985, sec. C, p. C1.
- Epstein, Irwin and Tripodi, Tony. Research Techniques for Program Planning, Monitoring, and Evaluation. New York: Columbia University Press, 1977.
- Erb, Lois; Hill, Gail; and Houston, Doreen. "A Survey of Parents' Attitudes Toward Their Cesarean Births in Manitoba Hospitals." Birth 10 (Summer 1983): 85-91.
- Ernst and Whinney, Accounting Firm. "Uses of DRGs By Medicare." New York: 1982 (Mimeographed).
- Fawcett, Jacqueline and Henklein, Joyce C. "Antenatal Education for Cesarean Birth: Extension of a Field Test." JOGNN (January/February 1987): 61-65.
- "Focus." Valley Advocate. Amherst, Massachusetts: 17 July 1985.
- Getzel, George. "Curricula for Group Work Practice in Health Settings: Process and Content." In Social Work in Health Services: An Academic Practice Partnership, pp. 55-64. Edited by Phyllis Caroff and Mildred Mallick. New York: Prodist, 1980.
- Gilbert, Neil. "Policy Issues in Primary Prevention." Social Work (July 1982): 293-97.
- Graziano, Roberta. "Post-partum Cesarean Support Groups: A Needs-Assessment Study." 1985. (Typewritten.)
- Guillemin, Jeanne. "Babies by Cesarean: Who Chooses, Who Controls?" Hastings Center Report 11 (June 1981): 15-18.

- Hedahl, Kathleen J. "Cesarean Birth: A Real Family Affair." American Journal of Nursing (March 1980): 471-2.
- Holmes, T.H. and Masuda, M. "Life Change and Illness Susceptibility." In Stressful Life Events: Their Nature and Effects. Edited by B.S. Dohrenwend and B.P. Dohrenwend. New York: Wiley, 1974.
- "Hospitals Facing Cuts and Closings as Stays Shorten." New York Times, 15 July 1985, p. 1.
- Jansson, Bruce S. and Simmons, June. "Building Departmental or Unit Power Within Human Service Organizations: Empirical Findings and Theory Building." Administration in Social Work 8 (Fall 1984): 41-56.
- Kahn, Alfred J. "Institutional Constraints to Interprofessional Practice." In Medicine and Social Work, pp. 14-25. Edited by Helen Rehr. New York: Prodist, 1974.
- Katch, Michael. "Commentary." Social Work in Health Care 8 (Spring 1983): 121-24.
- Kopeikin, Hal S.; Marshall, Valerie; and Goldstein, Michael J. "Stages and Impact of Crisis-Oriented Family Therapy in the Aftercare of Acute Schizophrenia." In Family Therapy in Schizophrenia. Edited by William R. McFarlane. New York: Guilford Press, 1983.
- Lefcourt, H.M. "Locus of Control and Stressful Life Events." In Stressful Life Events and Their Contexts. Edited by B.S. Dohrenwend and B.P. Dohrenwend. New Brunswick, N.J.: Rutgers University Press, 1981.
- Levy, Leon H. "Processes and Activities in Groups." In Self-Help Groups for Coping With Crisis. Edited by Morton A. Lieberman and Leonard D. Borman. San Francisco: Jossey-Bass, 1979.
- Lipson, Juliene G. "Effects of a Support Group on the Emotional Impact of Cesarean Childbirth." Prevention in Human Services 1 (1981): 17-29.
- _____. "Cesarean Support Groups: Mutual Help and Education." Women and Health 6 (Fall/Winter 1981): 27-39.

- Lipson, Juliene G. and Tilden, Virginia Peterson. "Psychological Integration of the Cesarean Birth Experience." American Journal of Orthopsychiatry 50 (1980): 598-609.
- Longan, Elaine Cooper. "Humanizing the Hospital Experience: Report of a Group Program for Medical Patients." Health and Social Work 5 (November 1980): 197-206.
- Lorsch, J.W. "Organizational Design: A Situational Perspective." Organizational Dynamics 6 (1977): 31-46.
- Lowe, Jane I. and Herranen, Marjatta. "Conflict in Teamwork: Understanding Roles and Relationships." Social Work in Health Care 3 (Spring 1978): 323-30.
- _____. "Understanding Teamwork: Another Look at the Concepts." Social Work in Health Care 7 (Winter 1981): 1-11.
- Lukton, Rosemary C. "Myths and Realities of Crisis Intervention." Social Casework 63:2 (February 1982): 68-74.
- Lurie, Abraham and Shulman, Lawrence. "The Professional Connection with Self-Help Groups in Health Care Settings." Social Work in Health Care 8 (Summer 1983): 69-77.
- McFarlane, William R.; Beels, C. Christian; and Rosenheck, Stephen. "New Developments in the Family Treatment of the Psychotic Disorders." In Psychiatry Update. Edited by Lester Grinspoon. Washington, D.C.: American Psychiatric Press, 1983.
- Marut, Joanne S. "The Special Needs of the Cesarean Mother." American Journal of Maternal Child Nursing (July/August 1978): 202-06.
- Marut, Joanne S. and Mercer, Ramona T. "Comparison of Primiparas' Perceptions of Vaginal and Cesarean Birth." Nursing Research 28 (Sept-Oct 1979): 260-66.
- Mayer, Robert. "Social System Models for Planners." In Planning for Social Welfare, pp. 273-289. Edited by N. Gilbert and H. Specht. Englewood Cliffs, N.J.: Prentice-Hall, 1972.

- Mercer, Ramona T.; Hackley, Kathryn C.; and Bostrom, Alan G. "Relationship of Psychosocial and Perinatal Variables to Perception of Childbirth." Nursing Research 32 (July/August 1982): 202-07.
- Mutryn, Cynthia S. "Psychosocial Impact of Cesarean Section on the Family: A Review of Recent Literature, Part II." ICEA News 23 (February 1984): 4-5.
- Nelsen, Judith C. "Support: A Necessary Condition for Change," Social Work September 1980: 388-92.
- "NIH Consensus Development Statement on Cesarean Childbirth." Bethesda, Maryland: Department of Health, Education and Welfare, 24 September, 1980. (Mimeographed.)
- "NIH Consensus Development Task Force Statement on Cesarean Childbirth." American Journal of Obstetrics and Gynecology 139 (April 15, 1981): 902-09.
- Northen, Helen. "Social Work Groups in Health Settings: Promises and Problems." Social Work in Health Care 8 (Spring 1983): 107-21.
- Oakley, Ann. "Social Consequences of Obstetric Technology: the Importance of Measuring 'Soft' Outcomes." Birth, 10 (Summer 1983): 99-108.
- Pearlin, L. and Schooler, C. "The Structure of Coping." Journal of Health and Social Behavior 19 (1978): 2-21.
- Perlman, Helen Harris. "In Quest of Coping." Social Casework 56 (April 1975): 2-25.
- Perrow, Charles. "The Analysis of Goals in Complex Organizations." In Human Service Organizations, pp. 234-52. Edited by Y. Hasenfeld and R. English. Ann Arbor: University of Michigan Press, 1974.
- Powell, Thomas J. "The Use of Self-Help Groups as Supportive Reference Communities." American Journal of Orthopsychiatry 45 (October 1975): 756-64.
- Rapoport, Lydia. "Crisis Intervention as a Mode of Brief Treatment." In Theories of Social Casework, pp. 129-179. Edited by Robert W. Roberts and Robert H. Nee. Chicago: University of Chicago Press, 1970.
- "Rate of Hysterectomies Puzzles Experts," New York Times, 20 September 1988, sec. C, p. C1.

- Reynolds, Bertha. Learning and Teaching in the Practice of Social Work. New York: Farrar and Rinehart, 1942.
- Rittel, Horst and Webber, Melvin. "Dilemmas in a General Theory of Planning." In Planning for Social Welfare., pp. 133-45. Edited by N. Gilbert and H. Specht. Englewood Cliffs, N.J.: Prentice-Hall, 1977.
- Rivlin, Alice. "Why Can't We Get Things Done?" Brookings Bulletin 9: 5-9.
- Rosenberg, Gary. "Advancing Social Work Practice in Health Care." Social Work in Health Care 8 (Spring 1983): 147-156.
- Rothman, Jack. "Promoting an Innovation." In Change from Within, pp. 241-2. Edited by Herman Resnick and Rino Patti. Philadelphia: Temple University Press, 1980.
- Schwartz, Marc D. "Situation/Transition Groups: A Conceptualization and Review." American Journal of Orthopsychiatry 45 (October 1975): 744-55.
- Scott, W. Richard. "Professionals in Hospitals: Technology and the Organization of Work." In Organizational Research in Health Institutions, pp. 139-58. Edited by G. Georgopoulos. Ann Arbor: Institute for Social Research, 1972.
- Shearer, Elizabeth C. "How do Parents Really Feel after Cesarean Birth?" Birth 10:2 (Summer 1983): 91-2.
- Tausig, Jane E. and Freeman, Ellen W. "The Next Best Thing to Being There: Conducting the Clinical Research Interview by Telephone." American Journal of Orthopsychiatry 58: 3 (July 1988): 418-27.
- Tripodi, Tony. Evaluative Research for Social Workers. Englewood Cliffs, N.J.: Prentice-Hall, 1983.
- Tripodi, Tony and Epstein, Irwin. "Incorporating Knowledge of Research Methodology into Social Work Practice." Journal of Social Service Research 2 (Fall 1978): 65-78.
- _____. Research Techniques for Clinical Social Workers. New York: Columbia University Press, 1980.
- Tripodi, Tony; Fellin, Phillip; and Epstein, Irwin. Differential Social Program Evaluation. Itasca, IL: Peacock Publishers, 1978.

Wallston, B.S.; Alagna, S.W.; DeVellis, B.M.; and DeVellis, R.F. "Social Support and Physical Health." Health Psychology 2 (1983): 367-91.

Wax, John. "Developing Social Work Power in a Medical Organization." Social Work 13 (1968): 62-71.

Weick, Karl. "Organizational Design: Organizations as Self-Designing Systems." Organizational Dynamics 6 (1977): 31-46.

Weiss, Carol H. Evaluation Research. Englewood Cliffs, N.J.: Prentice-Hall, 1972.

Weissman, Harold. "The Middle Road to Distributive Justice." Social Work (March 1972): 86-93.

_____. Overcoming Mismanagement in the Human Services. San Francisco: Jossey-Bass, 1973.

Wildavsky, Aaron. "The Self-Evaluating Organization." Public Administration Review (September-October 1972): 509-20.

Wortman, Camille B. "Social Support and the Cancer Patient." Cancer 53: 2239-2360.