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Research Article

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

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ABSTRACT

Background: Studies indicate that complex postsurgical wound healing can significantly alter biopsychological markers responsible for recovery. Yet, there is a lack of research investigating women's experience of living with slow-to-heal Caesarean birth wounds. This is an important area of investigation considering the increase of factors associated with surgical births and poor wound healing in the UK and globally.
Aim: The aim of this study was to explore women's experiences of living with a slow-to-heal Caesarean wound.
Method: Semi-structured interviews were conducted with seven women who had lived experience of slow-to-heal Caesarean wounds. Narratives were analysed using Interpretative Phenomenological Analysis (IPA) approach.
Results: Analysis of women's narratives revealed three interlinking superordinate themes of 1) 'Tied to that event': healing physical and emotional wounds, 2) The 'good mother' and the 'good patient': negotiating being a carer and being cared for, and 3) 'Adjusting to a new normality'. Overall, slow-to-heal wounds embodied women's perceptions of agency over their Caesarean birth experience and achievement of a new motherhood identity. Wherein, successful healing would encompass a sense of normality defined by subjective notions of regaining expected roles and daily activities, previous bodily functions, and maternal status within their families that became disrupted due to delayed wound healing.
Conclusion: Women's narratives support discourse surrounding Caesarean birth and recovery as a bio-psychosocial phenomenon. This has important ramifications regarding research and treatment programmes for postnatal women with complex healing that are largely described as 'invisible'.

Statement of significance

Problem or issue: Not much is known about how postnatal women experience delayed Caesarean wound healing, despite the increasing number of Caesarean births.

What is already known: Caesarean births are idiographic, and distinctive to other types of procedures.

Poor post-surgical wound healing can result in maladaptive patient adjustment and outcomes.

What this paper adds: Women's narratives of slow-healing Caesarean wounds are interlinked with the overall surgical birth experience and motherhood ideologies.

This contributes towards recommendations for tailored, holistic maternity care.

Introduction

Though Caesareans are regarded as a common and safe procedure in high- and medium-income countries (Keag et al., 2018), there are risks associated with Caesarean births as with other types of major abdominal surgeries; and these risks are on the rise, globally. Risks include patient factors such as older maternal age, immigration status and underlying medical comorbidities (The Scottish Government, 2021, Plassmeier et al., 2021, Bullough et al., 2015). An example of the latter is having a high body max index, with the rate of gestational obesity doubling in the

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UK between 2010 and 2018 (22 % and 44 % respectively; Childs et al., 2020).

Despite lack of consensus over the clinical definition of a slow-to-heal wound, there has been renewed interest into the biopsychosocial impact of wounds that do not follow common or expected healing trajectories (Webb, 2019; Lusher et al., 2018). Biopsychosocial approaches in wound care posits a whole person approach in treatment, in that the concept of healing is impingent on the interconnectedness between the physical manifestation of the wound and the subjective sense of *being* with the wound (Lusher, 2020). Research on patient experience with slow healing wounds have largely focused on older populations living with chronic leg ulcers, and more recently, patients living with acute wounds from general surgery (Pađen et al., 2022, Fearns et al., 2017; Alexander, 2013). However, despite the growing prevalence of surgical birth interventions, there is a clear gap in studies inspecting the experiences of post-Caesarean mothers with poor wound healing.

Existing studies on generic postoperative patients with slow healing wounds illustrate how perceptions of loss of control before or during surgery extends to the recovery period when prolonged wound healing manifests into complex feelings of lack of ownership over one's body and situation (Pinto et al., 2016). The vicious cycle of chronic pain, mood disturbances and maladaptive behaviours (movement avoidance) associated with atypical healing further impedes bio-protective healing mechanisms and overall sense of resilience (Alexander, 2013; Flink et al., 2009). This is particularly pertinent as the early postpartum period is already hallmarked by fluctuating hormones associated with a physiological response to emotive processes that impact recovery, such as pain and social support. Saxbe (2017) further explicates that clinical intervention during birth (Caesareans) can further complicate this intricate immunological system responsible for healing. Furthermore, Caesareans are unique in that women are discharged from hospital care with a new-born infant and a post-surgical wound to manage in addition to societal '*Good Mothering*' pressures of embracing psychically and emotionally demanding motherhood responsibilities (Jolly, 2017).

The biopsychosocial impact of postoperative birth and slow wound healing warrants further research due to the robust evidence that postnatal morbidity can impede mother-infant bonding and other factors important in attachment building (Quinlan, 2019). Increased understanding of women's needs can arguably not only inform betterment of support that is already available for women with complex healing Caesarean wounds, but also prevent poor outcomes via enhanced antenatal care. With this in mind, this study explored the emotional and psychosocial experiences of women recovering from slow-to-heal Caesarean wounds.

Methods

Design

This study employed Interpretative Phenomenological Analysis (IPA) to allow deeper insight into the idiosyncratic experience of living with a slow-healing postpartum Caesarean wound. The theoretical underpinnings of IPA dovetail with the study's aim of aligning with the biopsychosocial approach and the NHS (2012) commitment in offering personalised, woman-centred care.

The following inclusion criteria applied to the study: 1) Women who have given birth to a live infant via Caesarean in an NHS facility in the UK; 2) women with a good command of the English language, 3) women who had experienced delayed Caesarean wound healing within the past 24 months.

With regards to the last criterion, there is a lack of clinical guidance on what constitutes the 'normal' healing period for a Caesarean wound. Therefore, the study included non-prescriptive descriptors (e.g. wound that has re-opened or had not closed after 2 weeks) to help potential participants decide if they were suitable for the study.

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

Procedure and ethical considerations

This study received full ethical approval from the research ethics committee at the first author's academic institution.

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

Semi structured interviews

Flexible, semi-structured interviews using open-ended questions were implemented in order to allow for deeper examination of women's experiences of living with slow healing Caesarean wounds. Interviews are the primary data collection tools in IPA research as this gives the participant enough freedom to explore subjective experiences while still adhering to topics within research boundaries (Smith et al., 2012; Pietkiewicz and Smith, 2012). Interviews were conducted over video call or phone in accordance with university guidelines for conducting research safely during the Covid-19 pandemic and were transcribed verbatim.

Data analysis

A set of flexible, non-prescriptive guidelines advocated by Smith et al. (2012) in conducting an IPA analysis were followed. The first stage of analysis consists of reading and re-reading transcripts in order to '*immerse*' oneself within the narratives . This was followed by a free textual analysis; noting immediate thoughts and themes that summarise the content of each narrative on the lefthand margin of each transcript piece. The second stage consists of a more intellectual level of analysis involving abstraction of themes according to contextual relevancy and noting these on the righthand margin. This process of developing emergent themes requires magnifying sections of the transcript whilst still keeping a holistic grasp of the overall essence. Smith et al. (2012) describe this process as a '*synergistic process of description and interpretation*' (p.92).

After listing these emergent themes in chronological order in a separate Word document, further bottom-up processing was undertaken in order to cluster the themes into more economical sub-ordinate themes, paying close attention to themes that interact with each other symbolically. Master headings were then formed based on careful consideration of how clusters within sub-ordinate themes supplement each other. Finally, checking themes with evidence from the transcripts in the form of quotations further allowed for expansion of themes into a coherent account.

Qualitative research rigour

Yardley's (2000, 2016) four comprehensive principles were applied

throughout the study lifespan in order to uphold the trustworthiness of qualitative research:

1. Sensitivity and context: abiding by strict ethical guidelines in conducting interviews.
2. Commitment and rigour: Participant profiles in the form of individual brief case studies were sent to the participants in order to check for accuracy and minimise researcher bias.
3. Transparency and coherence: The lead author kept an 'audit trail' of reflexivity and decision-making in order to make transparent her own orientation within the research as someone who has never previously given birth via Caesarean. An independent researcher who was not connected to the study was also invited to audit the findings to ensure credibility.
4. Impact and importance: This study incorporated a Patient and Public Involvement (PPI) advisory panel who contributed towards shaping the study, e.g. by informing the participant eligibility criteria.

Results

Participants

Interviews with seven women were conducted between October 2021 and June 2022. Most interviews were approximately one hour in length (ranging from 34 min to 1 h and 11 min). Most interviewees identified as White ($N = 6$), and one as Black ($N = 1$). The majority were living with a partner during the period being investigated ($N = 6$), including one woman in a same-sex marriage. Most ($N = 5$) were in employment or self-employed, one worked up until the birth, and one was a homemaker. Five ($N = 5$) of the women had at least one previous Caesarean birth (see Table 1 participant summary table).

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

Findings

Analysis of women's narratives revealed three overriding themes of 'Tied to that event': healing physical and emotional wounds; The 'good mother' and the 'good patient': Negotiating being a carer and being cared for; and Adjusting to a new normality. Seven subordinate themes emerged from the three superordinate themes which attempt to illustrate the unique biopsychosocial experience of new mothers living with a slow-to-heal Caesarean wound. A diagram depicting inter-relatedness between themes can be found below (Fig. 1).

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

Maura's statement '*Tied to that event*' summarises in a few words how slow recovery is deeply anchored within the context of individual women's birth experiences. Healing physical and emotional wounds captures the mind-body connectivity apparent in the lived experience of delayed recovery from a Caesarean birth.

Regaining control over an unpredictable body

The women in this study described how the loss of agency over their complex healing wounds started shortly after birth. This was marked by graphic recollections of seeing their wounds for the first time, or intense emotions in noticing wound related complications. For example, the women interviewed used words such as '*puss-y*', and '*gushing*' to describe their sense of shock and aversion over their bodies that had suddenly become unknown and unpredictable.

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

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

Amanda's extract further describes the connection between persistent pain she was experiencing and her unwanted Caesarean. She offers further insight on how ongoing wound pain serves as a constant reminder that a meaningful event had not gone as planned:

'*it's I suppose because of the pain it's a reminder, it's a constant, it's just there*' (Amanda).

How things "should" have been

All of the mothers interviewed had a pre-conceived idea of what the birth and postpartum period should be like. For the women that underwent an unplanned Caesarean, a vaginal birth followed by a swift recovery was the expectation. Even women that had planned their Caesarean birth following a previous traumatic birth, anticipated that their recovery would be an improved experience.

These women expressed alarm and disbelief in registering the turn of events, as well as lack of preparation for the level and length of time they had to endure life disruptions caused by wound healing issues.

Table 1
Participant summary table.

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

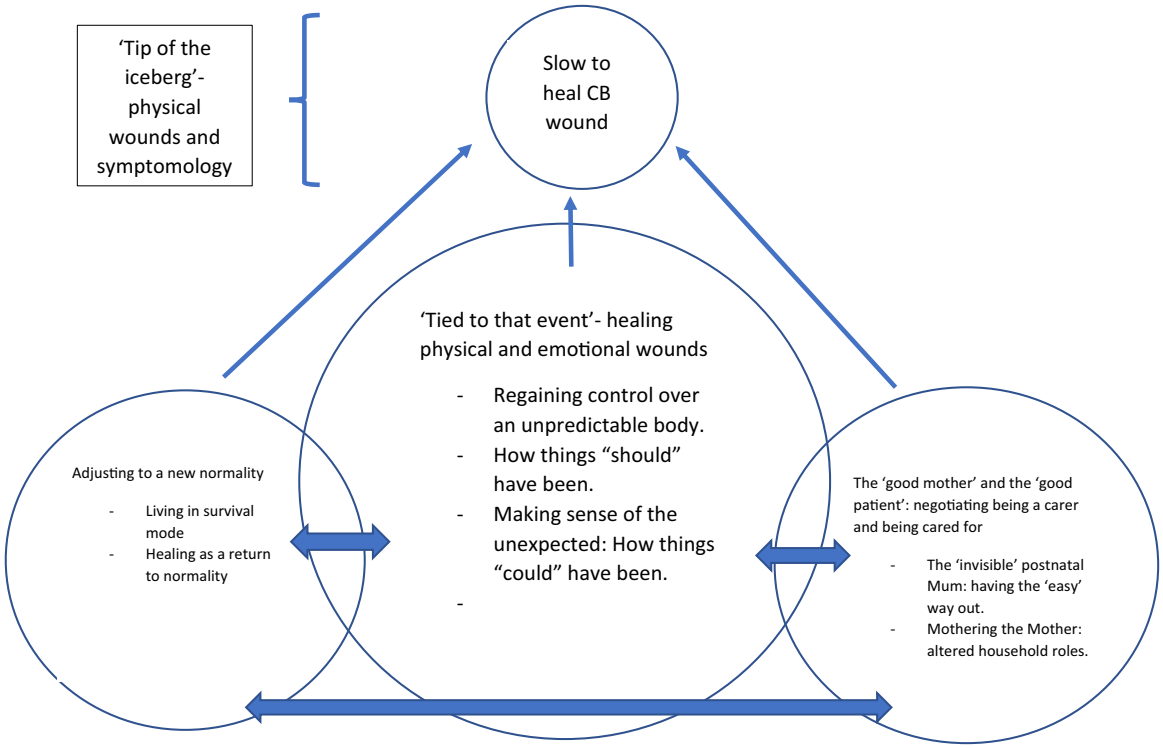

Fig. 1. IPA theme diagram.

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

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

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

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

Making sense of the unexpected: how things "could" have been

Most of the women strived to make sense of how they had acquired a slow healing Caesarean wound and described their attempts at problem solving their unprecedented situation. Women's reflections on how much control they had over how things "could" have been was often conflicting and contradictory within narratives:

'I think there's sometimes too much intervention, too early, and then… Like your body the way it's shape, like different pelvises… you know, it's not just as easy as you go into labour and the baby is just going to come on out' (Charlotte).

On the one hand, Charlotte's extract summarises women's experiences of self-blame. Delayed healing was caused by their own body 'failings'. For example, a body that necessitated surgical intervention at birth resulting in a slow-to-heal wound, or from damage caused by a previous Caesarean. On the other hand, women reflected how surgical birth leading up to complex healing was not under their control, but rather dictated by wider systematic pressures such as obstetricians' preferences for Caesarean procedures.

In order to regain control, women reported seeking alternative sources of information and support to increase knowledge, seek reassurance and de-mystify their condition. It is clear that the informational needs of the women in this study were not being met, as evidenced by most women expressing confusion over clinical prognosis and reporting lack of confidence in attending to the wound at home.

Overall, the women conveyed needing emotional support and practical information that transgresses the standard *'surface area'* (Harriet) post-Caesarean resources:

'so it's very much just um, guesswork really… you should be given a leaflet with information about how best to care for it (wound), and what you need to be careful about and what is the red, you know, what's a red alert if it gets worse, you know, what are the indicators of that, but there's nothing like that, so..' (Harriet)

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

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

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

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

Positive interactions with professionals were characterised as being treated as an individual, and women feeling listened to and taken seriously. Conversely, most of the women in this study expressed how poor or one-sided communication (being *'spoken at'*) with healthcare professionals contributed to feelings of isolation and loss of agency over wound management.

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

'I do not get how you, you know, if I had an operation for something else.. and have a wound looked at a later date, I think there would be a lot more around.. You know, has it healed, has the operation.. Has it gone as expected, (but) there is no follow up, there is no after care.' (Charlotte).

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

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

Mothering the mother: altered household roles

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

For example, some of the women's statements such as '*we split things 50–50 and stuff*' (Tina) and '*I'm lucky that my fiancé got the memo that it's the 21st century and men need to be hands-on'* (Harriet) insinuates an implicit division of household tasks that is congruent with modern family values. However, it became clear from most of the women's narratives that there were boundaries in regard to maternal role distribution within the family home. Despite most of the women's suggestion that they have eschewed traditional gendered roles, the sense of distress and guilt resulting from the women's compromised ability to fulfil mothering roles while recovering with slow healing surgical wounds was notable, especially within the narratives of women that had to negotiate caring for older children as well. There was a sense that these women felt continued role reversal in care giving duties caused long-term alterations within the family unit relationship dynamics:

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

Adjusting to a new normality

The sub-theme '*Living in survival' mode* illustrates how the women in this study negotiated disrupted attainment of maternal roles due to prolonged physical restrictions. The sub-theme *healing as a return to 'normality'* describes the women's aspirations and re-configuration of expectations as they learned to live with altered social and psychical functioning.

Living in survival mode

The women in the study described the practical adjustments they had to make to daily life routines in order to be able to fulfil their roles as new mothers as independently as possible. Most of the women interviewed described the complexity of their feelings at the time in retrospect. As an example, Maura used the wording '*whirlwind*' to hint at a sense of powerlessness over her situation while Sarah's extract '*On one sense it felt like a blur because the days just rolled into other days'* described the monotony of daily life imbued by immobility

Despite this, there was no opportunity for women to process their emotions at the time. Maura's explanation of how she '*just got on with it'* and similarly Lisa's choice of the wording *'soldiered on'* illustrate how for the women in this study, getting through expected daily life routines was seen as a responsibility to overcome without pause or questioning. Harriet's extract below also adds to understanding of societal 'good mothering' expectations of mothers as self-sacrificing, whereby the needs of the new-born and family are seen as the priority:

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

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

Healing as a return to 'normality'

Women's definition for what 'fully healed' would mean for them held strong resemblances across narratives. There was a general agreement that healing would mean 'feeling' and being able to undertake activities or behaviours that defined who they were before they became mothers.

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

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

Women's narratives illustrate how their feelings towards their Caesarean scar residue was complex and multifactorial. The majority of women reported how the scar '*twinges*' or '*shoots*' pain unexpectedly, triggered by common bodily reactions such as laughing. These women struggled to put into words the alien-ness of this new part of their body, words such as '*weird*' and '*strange*' were used to describe how the feel of the scar made women hyper aware of the concept of an altered self. Charlotte's extract illustrates how the '*feel*' of the scar, described by other women as '*hard*' and like a '*brick underneath the skin'* (Harriet), generates a sense of detachment from their bodies:

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

Discussion

Analysis of participants' interviews revealed three overarching themes of 'Tied to that event': healing physical and emotional wounds; The 'good mother' and the 'good patient': negotiating being a carer and being cared for, and 'Adjusting to a new normality'.

One key finding from this study is the strong immersion of women's Caesarean birth story within narratives of delayed postoperative wound healing. The titular quote '*Plan Z and then off the edge of a cliff'* (Lisa) captures the overall essence of the study findings. '*Plan Z'* characterises

how the Caesarean birth was a necessity as opposed to a desire for the women interviewed, in which the manifestation of slow healing wounds are primarily *tied to* the subjective Caesarean birth experience.

Studies ascertain how maternal adjustment is contingent on successful reconfiguring of the self in relation to how society deems a 'good mother' should be (Suplee et al., 2014; Mercer, 2004). Synonymous to the concept of being a 'good mother', the 'good patient' is traditionally described in literature as a person who is in essence accepting of medical advice without being challenging or a burden to omnipotent clinicians (Sointu, 2017; Brown et al., 2014).

Narratives suggest that the physicality of slow-to-heal Caesarean wounds embodies the emotional anguish caused by loss of postpartum expectations, which are symbolised by subjective 'good mothering' nuances. This corroborates existing findings stipulating that loss of a highly anticipated, socially defining period reduces self-efficacy during a time when women are already rendered more vulnerable due to significant hormonal and lifestyle changes (e.g. sleep disruptions; Quinlan, 2019).

Accounts also indicate that for the most part, healthcare staff responses to Caesarean wounds are seemingly guided by biomedical 'tip of the iceberg' approaches in assessing clinical wound parameters (see theme diagram, Fig. 1). This revelation mirrors wider concerns for the overall lack of holistic recognition of the person living with the wound in current healthcare policies and practice (Sen and Roy, 2019). In this sense, the sub-theme '"*invisible" postnatal Mums*' contributes towards current understanding of negative births, in that continued healthcare staff dismissal of women's concerns surrounding postoperative wounds can sustain legacies of disempowerment, as well as loss of agency and trust in one's own body stemming from the Caesarean birth.

The sub-theme '*Mothering the mother'* conveys the complex emotions women face in relinquishing control over significant household domains due to sustained injury. This theme complements existing findings suggesting that social support can inadvertently be maladaptive to postoperative patients (Pađen et al., 2022), and new mothers' psychosocial adjustment (Choi et al., 2005). Indeed, receiving unwanted support can have a reverse effect; creating feelings of role insecurity and exacerbate loss of agency in new mothers (Choi et al., 2005). Qualitative studies such as the current, illuminate that the experience of receiving social support is multifaceted, particularly in population groups (postpartum women) that are heavily guided by societal mandates surrounding gender roles. Rather, it appears that social support may improve recovery outcomes if perceived as enabling and giving back a sense of control during moment-to-moment interactions.

Lastly, the theme concept of '*Adjusting to a new normality'* is a key finding in other studies, from wound healing and childbirth literature spheres. For example, analysis of interviews with participants living with open surgical wounds resulted in one overarching theme of '*Negotiating a new normality'* (Pađen et al., 2022). There are striking similarities to the current theme *'Adjusting to a new normality'* in terms of the complexity of patients' experiences in adapting to the uncertainty and chronicity of an injured-self identity. However, there are also notable dichotomies surrounding the maternal and feminine self-identity as assemblies of a 'new normality' following a Caesarean birth. This separates the current study theme from findings derived from generic complex wound studies, and findings surrounding wounds derived from assisted vaginal births (e.g., anal sphincter injury; Darmody et al., 2020; Crookall et al., 2018).

Overall, this research adds to comprehension of how women's attempts to acclimatise to motherhood is disrupted by the negotiation of illness identities associated with slow-to-heal wounds, which does not cohere with stereotypes analogous with 'good mothering' schemas. The women in this study reported feeling minimised by healthcare staff that were perceived as representing societal 'good mothering' vindications of women that have given birth via Caesarean. This strengthens evidence pointing to a need for staff psychoeducation to nurture understanding of women's needs at organisational level, as well as provision of information appropriated to different levels of post Caesarean wound healing complexities.

Implications for practice

This study offers a holistic view of women's experiences of a postpartum that diverges from the norm due to postoperative birth wound complications. Women's narratives surrounding their experiences are multidimensional; thus strengthening the argument for a move towards a woman-centred, biopsychosocial approach in order to understand, prevent and manage poor Caesarean wound healing related outcomes.

It is inevitable that women with complex healing Caesarean wounds will come into contact with an array of healthcare professionals with varying levels of knowledge and attitudes towards wound care. The challenge remains designing and evaluating an equitable intervention or training packages that can be applied in a range of services, and to the full spectrum of patient need. Considerations for systems level communications and care pathways include:

- Working alongside patient experts in designing and piloting post-Caesarean discharge packages and information assets which are economical, but simultaneously tailored to women's subjective postoperative needs.
- Further investigation into how grassroots movements (e.g. Positive Birth Movement) can be harvested to instigate change at policy level, decrease stigma by increasing social awareness, and support women who may be more at risk from postnatal maladjustment or promote resilience in those already presenting with slow-to-heal Caesarean wounds.
- Sustainable staff training regarding wound diagnosis/aetiology, the psychosocial impact of Caesarean births and postoperative recovery, as well as empathic communications skills.
- Mobilising research to find the right balance between fast and efficient postoperative wound identification (e-health), whilst not negating postnatal women's needs for personalised care.

Study limitations and considerations for future directions

One methodological limitation worth considering is the exclusion of participants who cannot communicate in English proficiently. Additionally, the majority of participants were of White ethnicity, in a relationship at the time of birth, and with access to family support. One must be cautious in applying these findings to disadvantaged groups (for example, those with learning disabilities, immigrant women).

As interviews were conducted during the tail-end of the Covid-19 pandemic; one may question how transferable study findings are given women's experiences of care will depart from the norm due to extreme measures at the time. Though women's experiences during the Covid-19 pandemic are not typical of standard care, it can be argued that this study allows insight into the experiences of those who are less visible in academic participation and who are more likely to exist on the fringes of society. For example, newly arrived women who may lack confidence in navigating the UK healthcare system.

This highlights the need for further investigation into the experiences of women from ethnic backgrounds who are negotiating multi-agency systems set within cultural, gendered and political contexts.

Conclusion

This study has generated new considerations concerning the complexities of post Caesarean wound healing; findings suggest that women's resilience and ability to adjust to their slow-to-heal postnatal wounds are largely determined by the subjective meaning placed on the overall Caesarean experience as a juxtaposition between childbirth and surgery. This is important as it indicates a need to expand discourse surrounding post-Caesarean healing from one-size-fits-all formulations.

Post Caesarean wound care is an important area of development considering the link between poor postpartum adjustment and worsened mother-infant outcomes, in addition to the increase of risk factors underlying post Caesarean wound morbidity. Further research is suggested to capitalise on directives toward person-centred ethos in both wound and maternity care guidelines.

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CRediT authorship contribution statement

Clementine Djatmika: Conceptualization, Methodology, Formal analysis, Investigation, Resources, Writing – original draft, Writing – review & editing. **Joanne Lusher:** Conceptualization, Methodology, Supervision, Writing – review & editing. **Heidi Williamson:** Supervision. **Diana Harcourt:** Conceptualization, Supervision.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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