*'It will dictate how many children I will have"-*Women's decision-making in pregnancy following a previous caesarean birth (CB)

Key words: Decision-making, women's experiences, birth-choice uncertainty, VBAC (Vaginal birth after Caesarean), CS (Caesarean Section), previous caesarean birth (CB), Grounded Theory (GT).

Abstract:

Vaginal birth after caesarean (VBAC) is supported in systematic reviews (Wu *et al*., 2019) and national guidelines (RCOG, 2015) and women are expected to be involved in the decision-making process for either a repeat caesarean birth or planned VBAC.

Aim: To develop a Grounded Theory (GT) of women's decision making of their birth choices in pregnancy following a previous caesarean birth (CB)

Objective: To explore what determines women's birth choice and their decision making for birth following a previous CB.

Design: Semi structured interviews with pregnant women were undertaken in order to develop a Glasserian Grounded Theory

Setting: Antenatal clinics and wards in a large tertiary level maternity hospital.

Findings: The theory of 'Mentalizing Possibilities' is a substantive theory which explains pregnant women's decision making about their birth choices after a previous CB. Women's main concern is to achieve a positive experience. The core category of 'Mentalizing Possibilities' explains how women process their previous experience, adapt to uncertainty and deal with the decisional conflict. There are behavioural and cognitive strategies which women use to go through this process.

Conclusion: Women want a positive birth experience after a previous CB and require support and continuity in decision making to help them decide the optimal birth choice for their current pregnancy.

Introduction:

Caesarean Birth (CB) rates are rising in both developed and developing countries (WHO, 2015) and are five times more frequent in high resource countries compared to low and middle-income countries (Boerma *et al.*, 2018). The mode of birth after a previous caesarean can be either a repeat CB or VBAC. Planned VBAC is a clinically safe choice for most women with a single previous caesarean birth (RCOG, 2015; Guise *et al*., 2010).

Unquestionably, CBs are life saving interventions, but overmedicalisation of some procedures in childbirth can have serious long-term side effects on the mother and the baby (European Perinatal Health Report, 2018). Women struggle in decision- making for a choice of birth after a previous CB (Lundgren *et al.*, 2012). This is not only because of a lack of availability of choices (Hadjigeorgiou, *et al.,* 2021), but also because of the fragmented organisational structures, and inadequate inter-professional communications which leads to lack of women's participation in the decision-making process. Hence, women's informed consent can be questioned (Hanafin and Dwan O'Reilly, 2016; Lundgren *et al.*, 2012; McGrath *et al*., 2010).

The manner in which a birth-choice is presented is important in decision-making. The use of decision aids and information programmes can increase knowledge and reduce decisional conflict (Eden *et al.*, 2014;Chen and Hancock, 2012; Emmett *et al.*, 2007; Shorten *et al.*, 2005) but do not seem to have a significant effect on increasing VBAC rates (Wise *et al.*, 2019; Nilsson *et al*., 2015). What is also unknown is what determines women's choice and how they actually make a choice.

This study aimed to explore what determines women's birth choices and how they make their decision for birth in pregnancy following a previous CB, with a view to generate a theory about this phenomenon of interest.

Methods:

A number of studies have sought to explain women's experiences of decision-making about CB (Coates *et al*., 2021; Tolmacheva, 2015; Lundgren *et al.*, 2012; McGrath *et al*., 2010; Moffat *et al.,* 2007), but there has not been an attempt to develop a theory in relation to this topic. Hence, the need to undertake a study was identified, to explore what matters most to pregnant women, what their childbirth preferences are and to what extent they are involved in making birth choices.

Classic Grounded Theory (GT) methodology was selected with a view to generating a theory and to provide an explanation for this complex process of decision-making. The aim was to generate a conceptual theory to explore the problems, processes, and patterns that women experience (Glaser, 1992, 2003). This was in contrast to descriptive (Strauss and Corbin, 1998) or interpretive theory generation (Charmaz, 2014). The objective was to reveal the true concern of the participants without preconceiving the problem and potentially leading the data into preconceived interpretations (Glaser, 1998). From a GT perspective, the question to explore became, 'what is women's main concern in pregnancy after a previous CS?'

Ethical approval was obtained by the Cork Research Ethics Committee (CREC).

Pregnant women, who had one previous CB, were recruited on antennal clinics and wards in a large tertiary level maternity hospital. Data collection and analysis was undertaken simultaneously as per the Constant Comparative method of data analysis (Glaser, 1998). Fifteen formal open-ended, semi-structured interviews were conducted, recorded and examined line by line. Initially, in the open coding stage, repeated patterns and incidents were coded and highlighted for use in subsequent interviews and for analysis purposes. This aided the comparison of incidents to incidents, code to code, and later, category to category. Categories and sub-core categories were identified and the core category, began to emerge at the end of the formal interviews. When the substantive theory began to appear, selective coding started.

Fifteen further informal interviews were undertaken. These were unstructured short interactions lasting (5-15) minutes identifying incidents and patterns until data saturation was reached. In addition, two non-participant observations were undertaken at hospital VBAC classes. Field notes were used to record the data from the informal interviews and non-participant observations. An opportunity arose to follow one woman throughout her pregnancy which enhanced integrating the concepts into the emerging theory.

Theoretical coding was undertaken whereby, the theory was refined by integrating categories and sub-categories using theoretical codes. Memos were written throughout the process whenever and wherever an idea was indicated.

Participants' anonymity was maintained and memos were assigned with dates, referenced to the corresponding interview number. Field notes were dated, names were not used. In addition, there were no identifying characteristics evident in the theory, as the unit of analysis was the behaviour rather than the individual. Participant quotations are used to explain the theory, these are assigned with numbers of the participants.

Findings:

The findings are presented by the core category of 'Mentalizing Possibilities'. The meaning of 'Mentalizing' in this theory is 'to process', and 'Mentalizing Possibilities' means to process the choice in pursuit of a positive experience. This involves pregnant women processing their previous experience, adapting to uncertainty and dealing with the decisional conflict of their birth choices in their current pregnancy.

To achieve this, they use behavioural and cognitive strategies. Every woman goes through this process but uses different strategies. Accordingly, women's behavioural strategies are classified into four types. They are 'uncertainty acceptor', 'innocent modifier', 'slippery sloper' and 'comfort seeker'. Women's self-determination leads to the development of an awareness, which enables them to mentalize possibilities. The cognitive strategies women use, go through three stages: 'possibility seeking', 'probability distancing' and 'reality re-seeking'. Women mentalize possibilities by engaging actively or passively during these three stages of decision making. The outcome of the process is to achieve a positive birth experience. This theory is explained below in terms of its core and sub-core categories by providing examples from the data gathered from women.

Behavioural strategy of mentalizing possibilities

Women's self-determination

As mentioned above, women have a degree of self-determination, which is used to achieve something they value. This becomes an important pre-condition for 'Mentalizing Possibilities'. This self-determination leads to a sense of hope about a choice, and perception of control.

There are internal (personal factors) and external (contextual) factors that lead to women's self-determination. Internal factors include women's beliefs about birth, their values and their attitude about pregnancy and childbirth. External factors include the support system and the information women encounter in pregnancy, debriefing of the previous birth, the language and attitudes of health professionals, the influence of family and friends, the consistency of the information provision and continuity of care.

I will go for a natural birth if I can, I missed out on so much last time . . . If the pain is very severe, I will go for the epidural. That will be the last-minute decision because I don't want to have another section if possible (P4)

Self-determination and awareness are interrelated. For some women, their self-determination ('uncertainty acceptors' and 'comfort seekers') enables them to develop awareness of a birth choice. Awareness has three contextual factors, personal, informational and support contexts.

Classification of women's behaviour based on self-determination

Uncertainty acceptor

Women, who have strong self belief, are determined to experience VBAC. They engage in positive self-talk, embrace uncertainty easily, and believe in the natural aspect of pregnancy and childbirth. Strong self-determination enables them to deal with the uncertainty around birth. They consider risk as 'either way' as there is risk involved in both choices. They are aware that this pregnancy is the only opportunity to achieve VBAC.

I would like to experience a natural birth, a proper birth, it is a rite of passage for women to do . . . if I have to have a section this time, . . . my next baby will be section. So, this is the last chance . . . to have that experience. (P15 In-patient for unstable lie).

Innocent modifier

Innocent-modifiers believe that they have weak self-determination, they are unaware of their choices at the beginning of the pregnancy. However, with information and support their self-determination can be enhanced from weak to strong, they can build up or change their awareness and can become increasingly determined to achieve their choice (VBAC).

I'll go through the vaginal birth and see if I can make it work and I will try because the doctors said it was better. They said that I should try the vaginal birth and …. also because of the risks in the C-section. Yes, I am going to take doctor's advice (P12)

Slippery sloper

Slippery-slopers also have a perception of weak self-determination because of how they value uncertainty. Information and support can boost their self-determination but they give up easily when uncertainties increase or overtake the situation, they do not place a high value on achieving a normal birth.

I wasn't comfortable with the decision being in my hand . . . if somebody could guarantee me a natural birth . . . then I would. That's why I like the idea of a section, but I would love if the decision is made for me that I would have to have a section (P3)

Comfort seeker

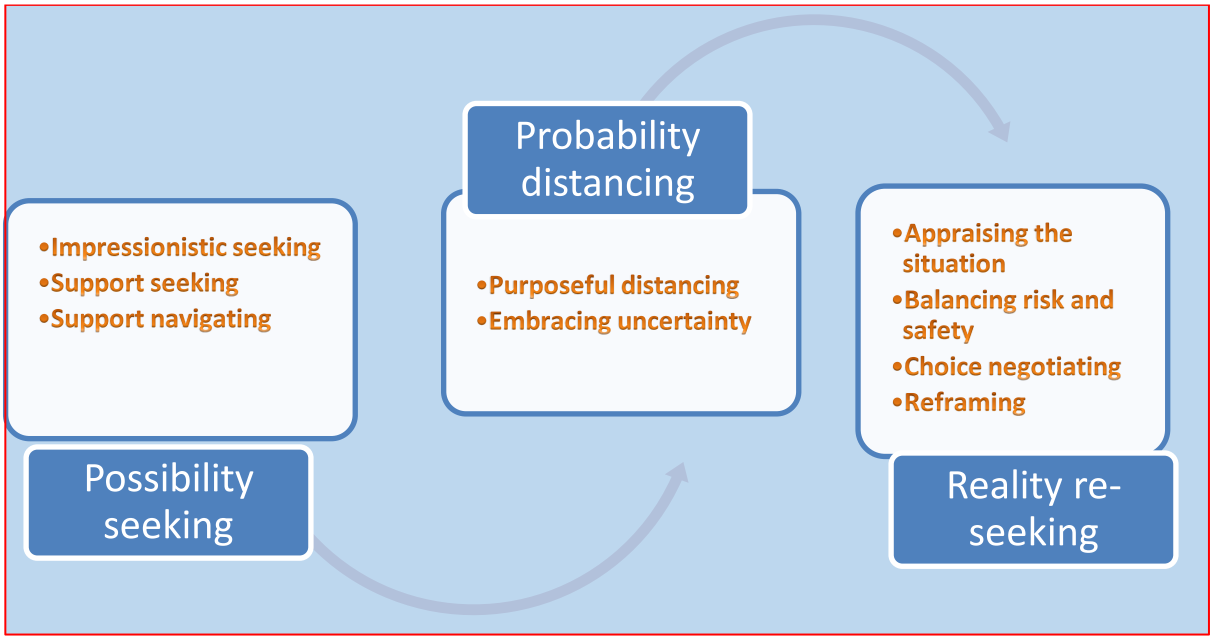
Comfort-seekers also have a consciousness of strong self-determination but are focused on a particular outcome, birth by CB. They are comfortable with their previous experience (CB) and are aware of the choices. They value convenience and certainty more than a normal birth. It is difficult to change their self-determination even with counselling, education or with support.

> *I want to stick with what I know. I had decided that I would opt for CS from the beginning of the pregnancy. I would like to have a plan in place . . .. There are hardly any problems with CS (field note 9, previous CB for breech, planning for repeat CB)*

Cognitive Strategies of mentalizing possibilities

Cognitive strategies involve processing the previous experience and the information, by adapting to uncertainty and dealing with the decisional conflict. Women go through three stages, 'possibility-seeking', 'probability-distancing' and 'reality re-seeking', which are sub-core categories. They are cyclical, they may be interrelated, or they may overlap depending upon women's awareness.

Figure 1 showing Cognitive strategies in different stages of pregnancy



Possibility seeking

This occurs in early pregnancy where women look for information and support for a choice. There is heightened awareness among women, but how they process information varies depending upon their belief about birth, and their awareness of the information and support. When the perception of self-determination is strong, women overcome barriers and uncertainties easily. When their perception of self-determination is weak, they are more likely to experience decisional-conflict. In order to participate in future decision-making, these women need considerable support in early pregnancy in the form of counselling and information.

In ‘impressionistic seeking’, women gather cues and information about aspects of childbirth and create an opinion about their birth choices. Women engage in information seeking if not debriefed/counselled effectively.

> *I have discussed with few friends… one who had a section with the first and had natural with the second, she had ‘episiotomy’ and . . .she said the recovery was worse after that (episiotomy) than after the section (P3)*

Women’s perceptions of social norms and social acceptance of a type of birth also contributes to the choice they make.

> *when I attended the breastfeeding groups, I found that there was a lot of discrimination. I found it very tough actually, people were really anti-section (P1)*

Impressionistic seeking leads women to engage in seeking support, where they seek help, information and support in favour of their pre-determined choice.

> *My mother is great, she had us naturally. I told her I was worried. She said, ‘your body knows what to do, it is a natural thing, it is not easy, but you must trust in your body’. She felt the midwives were great, so the support here has been very good, I couldn’t fault anybody really (P5).*

For some women, their experience of pregnancy may have included an untoward event, poor or unsatisfactory care, and lack of continuity and support. This could lead women to ‘navigating support’.

> *We went to a 20-week appointment and I was trying to ask the doctor the question . . . as I was speaking to him, he was walking out the door. I was told to ask my GP, and GP was saying talk to the consultant, . . . I felt that nobody was taking responsibility for this, and that I was falling in between two stools and if something happens, nobody is ever going to take responsibility (P15)*

Probability Distancing

This takes place mid pregnancy where women cope with the inconsistency and uncertainty of information and support by passive participation in decision-making. They do this by concentrating on the current pregnancy and trying to enjoy it.

‘Purposeful distancing’ is where women consciously stay away from making a choice due to their inability to overcome the inconsistent information they encounter and often a negative previous birth experience. They remain open to accept all probabilities (uncertainty acceptors). Some engage in avoidance, which is also a form of 'purposeful distancing'. For women who have a favoured choice of VBAC, they try to avoid information that distracts them from their choice; similarly, for women who have chosen repeat CB, they avoid information that will deter them. Women consider these as 'known' and 'unknown' fears.

> *I was a little fearful I would carry the baby full term. As I went on, I put it to the back of my mind, and I didn't think about it, waiting to see…I had an extra scan . . . this pregnancy was definitely easier than the last pregnancy" (P11)*

> *I think the fear of the unknown, and probably fear of being told all the bad things that can happen. "Your scar can rupture" "you have the risk of placental abruption." you hear all the negative things. But there are a lot of positive things that can come out of trying to achieve a vaginal birth. (P 8)*

An increased sense of control is likely to result in mentalizing by 'wait and see', blocking, ignoring, embracing and 'blurring' the previous experience. When women feel in control, they are open to options and will follow a 'wait and see' policy. When women are deferring their choice, the information that provokes them to think about that choice, is neither sought nor welcomed.

Reality Re-seeking

Towards the end of pregnancy, the forthcoming birth triggers 'reality re-seeking' where the decision making for the birth-choice becomes a reality. This is a stage of heightened awareness but time and situational pressure leads to poor processing of information.

The first step in reality re-reseeking is to appraise the situation in terms of evaluating the available time, information, and support. Reality re-seeking can be a way to shift responsibility to the 'expert'. This happens when there is limited time and there is an opportunity to transfer the decision to someone else, usually a doctor. This is important for 'innocent-modifiers' and 'slippery-slopers', who have been unable to overcome their decisional conflict and choice-uncertainty. A lack of support acts as an antecedent to their birth-choice uncertainty and their decisional conflict. Women in private obstetric care spent less time in this stage as the decision about the choice was already made earlier in the pregnancy for most women during the period of possibility-seeking.

> *I knew anyway, that once you have a section that you were more likely to have another section, a friend of mine, who had her second baby, who also had an emergency section told me that you can no longer be induced, I didn't realise that. I also didn't realise that you can only have a certain number of sections, so if I am going to have it (CS) will be dictating how many children I am going to have, I didn't realise all that until later on in this pregnancy" (P15).*

As the pregnancy advances, balancing risk and safety becomes paramount and women calculate the odds of a VBAC success. Some still opt for choice in spite of the odds being against that choice.

> *They have pointed out about the wound, how it could tear . . . It didn't put me off; there is a risk in everything you do so it is the level of risk you calculate. I think once you have the percentage of facts you make the decision and that's what I did (P1).*

> *I would be worried about . . . all sorts of things. I don't like hearing about words like 'forceps', 'rip' associated with a natural delivery. I would be nervous … an elective section; it is planned as opposed to 'emergency'. So, I am not worried about the safety with the section. I don't have any concern with the elective section (P 3)*

At this stage, an inability to balance risk triggers uncertainty for some women. Decisional uncertainty is more likely related to the previous experience of failure than the odds of success of VBAC. Previous issues such as, failure of onset of a spontaneous labour, the need for induction of labour, failed progress in labour, foetal distress or preterm labour were issues for women to consider in balancing risk and safety. The odds are in favour of planned elective CB as it is perceived as a safer choice, this may to be related to the health professional preference for that choice.

> *"In my first pregnancy . . . there was a statistic that 36% of births in private sector and 25% in the public sector were sections and I think that there should be no difference in that percentage, it shouldn't matter what system you are under . . . Why is it that private sector the percentage is higher, it is this element of whole too posh to push?" (P2)*

When the odds are against their preferred choice, women are forced into negotiation with the doctor. Both parties reach common ground to resolve the women's main concern of achieving a positive birth-experience. This becomes easier when health professionals listen to women's concerns and when there is mutual trust. If the practitioners are positive and show a confident attitude towards what they are recommending, they can influence women's decisions, particularly for women who are 'innocent modifiers' and 'slippery slopers'.

'Re-framing' happens when the possibilities are exhausted, women change how they want to describe their birth for a positive experience, they come to terms with the actuality of the situation. There are three possibilities in re-framing. The first is adhering to one choice over another. Where women are not able to select their preferred choice, the rejected choice receives negative re-enforcement with the prediction of failure, and concerns about complications (rejecting VBAC). The second outcome of re-framing is adherence to the decided choice even in the face of negative information concerning the choice (choosing VBAC). This is where safety is not an issue (uncertainty acceptors). The third outcome of re-framing is that women may have to compromise on their commitments and reframe their definition of the birth-experience for the safety and well-being of themselves and their babies (wanting VBAC, but opting for CS). They do this because of medical advice and also because they want to avoid post decisional regret.

Discussion

Women's perception of birth choices revolves around the concept of uncertainty which has a major role in decision making. An event can be considered uncertain if it has vagueness, lack of clarity, ambiguity, unpredictability, inconsistency, probability, multiple meanings and lack of information. It can arise when women are unable to assign probabilities for outcomes through cognitive, emotive or behavioral reactions (Penrod, 2001). Lack of support and informational inconsistency led to women's birth-choice uncertainty can be compared with the theories of Lazarus and Folkman (1984) and Janis and Mann (1977).Women (slippery slopers and comfort seekers) felt that knowing in advance when the event is going to happen (elective CB) gave them more certainty, however, women who were self-determined to go through labour, were ready to go through that uncertainty as they accepted uncertainty as a part of decision-making process. Hence, their coping was one of 'defensive avoidance' where they show a lack of interest in the problems posed by the situation, become selectively inattentive to cues and avoid thinking about a choice (VBAC/CB) by distracting/distancing themselves with other activities. Slippery-slopers also were involved in 'buck-passing' where a person depends on someone else to make the decision. Comfort seekers ignored the available information or arguing against evidence of its potentially unsafe features (such as VBAC). Most of the uncertainty literature, available to date explains uncertainty in illness-related situations and negative psycho-social outcomes, hence, this research is a contribution to the field of birth-choice uncertainty in pregnancy after a previous CB.

Women's self determination and their belief about birth belief either as a medical or natural process determine how they 'Mentalize Possibilities'. This adds to the literature, that women's belief about birth as a natural process, is related to optimism and anticipation; a belief that birth is a medical process is related to anxiety and fear of birth (Preis *et al*., 2018, Preis and Benyamini, 2017; Black *et al*, 2016; Shorten and Shorten, 2014;Handelzalts *et al.*, 2012; Gamble *et al.*, 2007; Fenwick *et al*., 2007). This might be an explanation why some women are undecided about their choices until late in pregnancy.

Information provision, especially risk information can have significant influence on women's decision-making (Lundgren *et al*., 2012; McGrath *et al*., 2010; Goodall *et al*., 2009). Some women, attending a busy clinic, found that information received was just one or two sentences at the end of their pregnancy. This is a time when their information processing was weak due to the imminence of the birth and the constraints of either, the busy hospital clinic or being placed on a theatre list. Hence, they show inability to process information and support due to perceived time pressure and situational pressure.

Women left clinics with inadequate knowledge, seeking support and information elsewhere or from others. However, informational support based on the risk and safety information alone is not enough in managing decisional uncertainty and to process the choice, which is a contribution of this theory. Health professionals can have difficulty providing information where their judgements of probability can interfere or overlap women's judgement or how women interpret the information(Reyna, 2008). Women can perceive risk differently with different models of care, the bio-medical/technocratic birth model or the social/midwifery model of care (Davis-Floyd, 2001;Symon, 2006; Downe, 2008; MacKenzie Bryers and van Teijlingen, 2010; Loke, Davies and Li, 2015). This theory suggests that the biomedical model alone is not enough in pregnancy and challenges the notion of risk, based on a bio-medical model. Pregnant women's understanding of risk is contextual (Davis *et al.*, 2020). Women base their decision on personal, practical, expereintial and social factors rather than clinical outcomes alone (Flannagan and Reid, 2012; Black *et al.*, 2016; Munro *et al*., 2017; Davis *et al.*, 2020). Further adding to the complexity, and to the relative simplicity of the bio-medical model, is that women prioritise achieving a positive birth experience over risk, irrespective of the choice of CB or VBAC. It can be argued, that concentration on statistics can lead to increased intervention in childbirth, which undermines the woman's confidence in her ability to birth her baby (Symon, 2006).

This study adds to the debate that the subjective perception of risk can be totally different from the objective perception of risk. Some women were so passionate about their choice, that they could not remember much of the information about risk and safety, but were aware that their particular choice best suited them. This is one of the reasons for women's decisional conflict as their belief in achieving VBAC is not positively encouraged. Hence, physician centredness is a barrier for VBAC update (Panda *et al*., 2018; Lundgren *et al.*, 2015;Firoozi *et al.*, 2020; Panda, Begley and Daly, 2018). These organizational factors such as provider preferences and practice patterns, in addition to the personal factors can influence women's' preference for a choice right from the beginning of the pregnancy (Shorten and Shorten, 2014). This theory explains that while the birth of a healthy infant is paramount, women's experiences with their pregnancy, childbirth and transition to the postnatal period are equally important. It is important for health professionals involved in women's care to consider this process as a holistic approach rather than as a quick fix process to suit the convenience of the busy hospital or the health professional.

Along with the other studies, women's satisfaction with the previous birth (Shorten and Shorten, 2012;Tolmacheva, 2015;Akgün and Boz, 2019) can influence their choice. Women deal with their previous birth experiences by reframing, re-integrating and internalising a previous traumatic birth to achieve a positive birth with appropriate support (Thomson and Downe, 2010; 2013; 2016). Unfortunately, this type of support, in the form of a debrief service or supportive carer, is not always available at busy antenatal clinics, as a result woman are not able to connect with a health professional and create a relationship of trust, mutuality and respect. This theory along with the previous studies (Ryding *et al.*, 2015; Karlstrom *et al.*, 2011;Panda, Begley and Daly, 2018) explain the reason for women's fear and anxiety and if this is unresolved women either opt for or forced into request a repeat CB.

This theory compares with a shared collaborative decision-making model to support women in a preference-sensitive context such as VBAC vs repeat CS (Charles, et al, 1997; 1999). Along with Elwyn *et al*., (2012) and Stiggelbout *et al*., (2015), this theory proposes that 'possibility seeking' compares with 'choice talk' and 'option talk' where women are seeking informational and emotional support to make an informed choice and re-seeking reality compares with the 'decision talk', where women want support in finalising their decision. The theory advocates for reciprocal engagement by health professionals at every stage of decision making, along with constant evaluation of women's coping with the decision-making process (Witt *et al.*, 2012). Decision aids can supplement the shared decision-making process (Wise *et al.*, 2019), but do not replace the engagement and continuous support by a professional. This continuous support leads to satisfaction with women's decision-making process irrespective of the choice they make. In the study setting, some women were not aware of a choice and women who accessed public care, lacked continuity of care as they did not see the same health professional at every visit. This was one of the reasons why women chose private care in their second pregnancy.

This theory emphasizes on the context and the process of decision-making, in helping women to process the previous birth experience. It is also important to focus on the positive outcomes that can result by providing timely and appropriate support for women. This will enable them to process birth-choices uncertainty into an opportunity and can give them that positive experience which they are hoping to achieve.

Conclusion: This theory outlines the multifactorial means by which women make decisions in practice about their birth choice following a previous CS. The study extends other theories by suggesting how birth experience could be much more positive for women by not concentrating on the choice alone, but on the process of how and why women make those choices and in supporting their choices. It recommends the importance of understanding not only the informational needs for women but also their psychological needs and particulary reveals that many women suffer from a lack of choice, control and continuity. A women-centred holistic approach to the decision making process is lacking for many pregnant women in pregnancy after a previous CS. This theory like other research has identified issues and some possible solutions in bringing about continuity in decision making and ensuring a positive experience. It can be used as a basis for supporting women in decision-making for a choice after a previous CS; material that is currently lacking in the midwifery and decision-making literature in this substantive area. This theory calls for health professionals to understand women’s concerns and to support and assist them to achieve a positive experience.

References:

Akgün, M. and Boz, İ. (2019) 'Women's decision-making processes and experiences of vaginal birth after caesarean birth: A phenomenological study', *International Journal of Nursing Practice (John Wiley & Sons, Inc.),* 25(6), pp. N.PAG-N.PAG.

Black, M., Entwistle, V. A., Bhattacharya, S. and Gillies, K. (2016) 'Vaginal birth after caesarean section: why is uptake so low? Insights from a meta-ethnographic synthesis of women's accounts of their birth choices', *BMJ open,* 6(1), pp. e008881.

Boerma, T., Ronsmans, C., Melesse, D. Y., Barros, A. J. D., Barros, F. C., Juan, L., Moller, A.-B., Say, L., Hosseinpoor, A. R., Yi, M., de Lyra Rabello Neto, D. and Temmerman, M. (2018) 'Global epidemiology of use of and disparities in caesarean sections', *Lancet (London, England),* 392(10155), pp. 1341-1348.

Charles, C., Gafni, A. and Whelan, T. (1997) 'Shared decision-making in the medical encounter: What does it mean? (or it takes at least two to tango)', *Social Science & Medicine,* 44(5), pp. 681-692.

Charles, C., Gafni, A. and Whelan, T. (1999) 'Decision-making in the physician–patient encounter: revisiting the shared treatment decision-making model', *Social Science & Medicine,* 49(5), pp. 651-661.

Charmaz, K. (2014) *Constructing Grounded theory.* second edn. London: Sage publications.

Chen, M. M. and Hancock, H. (2012) 'Women's knowledge of options for birth after Caesarean Section', *Women Birth,* 25(3), pp. e19-26.

Coates, D., Donnolley, N., Thirukumar, P., Lainchbury, A., Spear, V. and Henry, A., 2021. Women's experiences of decision-making and beliefs in relation to planned caesarean section: A survey study. *Australian and New Zealand Journal of Obstetrics and Gynaecology*, *61*(1), pp.106-115.

Davis, D., S Homer, C., Clack, D., Turkmani, S. and Foureur, M. (2020) 'Choosing vaginal birth after caesarean section: Motivating factors', *Midwifery,* 88, pp. N.PAG-N.PAG.

Davis-Floyd, R. (2001) 'The technocratic, humanistic, and holistic paradigms of childbirth', *International Journal of Gynecology and Obstetrics,* 75, pp. S5-S23.

Downe, S. (2008) *Normal childbirth : evidence and debate.* 2nd edn. Edinburgh ; New York: Churchill Livingstone/Elsevier.

Eden, K. B., Perrin, N. A., Vesco, K. K. and Guise, J.-M. (2014) 'A Randomized Comparative Trial of Two Decision Tools for Pregnant Women with Prior Cesareans', *JOGNN: Journal of Obstetric, Gynecologic & Neonatal Nursing,* 43(5), pp. 568-579.

Elwyn, G., Frosch, D., Thomson, R., Joseph-Williams, N., Lloyd, A., Kinnersley, P., Cording, E., Tomson, D., Dodd, C., Rollnick, S., Edwards, A. and Barry, M. (2012) 'Shared decision making: a model for clinical practice', *Journal of General Internal Medicine,* 27(10), pp. 1361-1367.

Emmett, C. L., Murphy, D. J., Patel, R. R., Fahey, T., Jones, C., Ricketts, I. W., Gregor, P., Macleod, M. and Montgomery, A. A. (2007) 'Decision-making about mode of delivery after previous caesarean section: development and piloting of two computer-based decision aids', *Health Expect,* 10(2), pp. 161-72.

European Perinatal Health Report, (2018). Euro-Peristat Project. European Perinatal Health Report. Core indicators of the health and care of pregnant women and babies in Europe in 2015.

Fenwick, J., Gamble, J. and Hauck, Y. (2007) 'Believing in birth--choosing VBAC: the childbirth expectations of a self-selected cohort of Australian women', *J Clin Nurs,* 16(8), pp. 1561-70.

Firoozi, M., Tara, F., Ahanchian, M. and Latifnejad Roudsari, R. (2020) 'Health care system barriers to vaginal birth after cesarean section: A qualitative study', *Iranian journal of nursing and midwifery research,* 25(3), pp. 202-211.

Flannagan, C. and Reid, B. (2012) 'Repeat CS or VBAC? A systematic review of the factors influencing pregnant women's decision-making processes', *Evidence Based Midwifery,* 10(3), pp. 80.

Gamble, J., Creedy, D. K., McCourt, C., Weaver, J. and Beake, S. (2007) 'A Critique of the Literature on Womens Request for Cesarean Section', *Birth,* 34(4), pp. 331-340.

Glaser, B. G. (1992) *Basics of grounded theory analysis : emergence vs forcing.* Mill Valley, Ca: Sociology Press.

Glaser, B. G. (1998) *Doing grounded theory : issues and discussions.* Mill Valley, CA: Sociology Press.

Glaser, B.G. (2003) *the grounded theory perspective II.* CA: sociology press.

Goodall, K. E., McVittie, C. and Magill, M. (2009) 'Birth choice following primary Caesarean section: mothers' perceptions of the influence of health professionals on decision-making', *Journal of Reproductive & Infant Psychology,* 27(1), pp. 4-14.

Guise, J.M., Eden, K., Emeis, C., Denman, M.A., Marshall, N., Fu, R.R., Janik, R., Nygren, P., Walker, M. and McDonagh, M., (2010). Vaginal birth after cesarean: new insights. *Evidence report/technology assessment*, (191), pp.1-397.

Hadjigeorgiou, E., Katsie, C., Papadopoulou, M., Christofi, M.D. and Christoforou, A., (2021). Women's experiences of VBAC in Cyprus: a qualitative study. *BMC Pregnancy and Childbirth*, *21*(1), pp.1-12.

Hanafin, S. and Dwan O'Reilly, E. (2016) *National and International review of literature on models of care across selected jurisdictions to inform the development of a National Strategy for Maternity Services in Ireland*

Handelzalts, J. E., Fisher, S., Lurie, S., Shalev, A., Golan, A., & Sadan, O. (2012). Personality, fear of childbirth and cesarean delivery on demand. Acta obstetricia et gynecologica Scandinavica, 91(1), 16-21.

Janis, I. L. and Mann, L. (1977) *Decision making: a psychological analysis of conflict, choice, and commitment.* New York: Free Press.

Karlstrom, A., Nystedt, A., Johansson, M. and Hildingsson, I. (2011) 'Behind the myth--few women prefer caesarean section in the absence of medical or obstetrical factors', *Midwifery,* 27(5), pp. 620-7.

Lazarus, R. S. and Folkman, S. (1984) *Stress, appraisal, and coping.* New York: Springer Pub. Co.

Loke, A. Y., Davies, L. and Li, S.-f. (2015) 'Factors influencing the decision that women make on their mode of delivery: the Health Belief Model', *BMC health services research,* 15(1), pp. 274.

Lundgren, I., Begley, C., Gross, M. M. and Bondas, T. (2012) ''Groping through the fog': a metasynthesis of women's experiences on VBAC (Vaginal birth after Caesarean section)', *BMC pregnancy and childbirth,* 12(1), pp. 85.

Lundgren, I., Smith, V., Nilsson, C., Vehvilainen-Julkunen, K., Nicoletti, J., Devane, D., Bernloehr, A., van Limbeek, E., Lalor, J. and Begley, C., (2015). Clinician-centred interventions to increase vaginal birth after caesarean section (VBAC): a systematic review. *BMC pregnancy and childbirth*, *15*(1), pp.1-9.

MacKenzie Bryers, H. and van Teijlingen, E. (2010) 'Risk, theory, social and medical models: A critical analysis of the concept of risk in maternity care', *Midwifery,* 26(5), pp. 488-496.

McGrath, P., Phillips, E. and Vaughan, G. (2010) 'Speaking out! Qualitative insights on the experience of mothers who wanted a vaginal birth after a birth by cesarean section', *Patient,* 3(1), pp. 25-32.

Moffat, M.A., Bell, J.S., Porter, M.A., Lawton, S., Hundley, V., Danielian, P. and Bhattacharya, S., (2007). Decision making about mode of delivery among pregnant women who have previously had a caesarean section: a qualitative study. *BJOG: An International Journal of Obstetrics & Gynaecology*, *114*(1), pp.86-93.

Munro, S., Janssen, P., Corbett, K., Wilcox, E., Bansback, N. and Kornelsen, J. (2017) 'Seeking control in the midst of uncertainty: Women's experiences of choosing mode of birth after caesarean', *Women & Birth,* 30(2), pp. 129-136 8p.

Nilsson, C., Lundgren, I., Smith, V., Vehvilainen-Julkunen, K., Nicoletti, J., Devane, D., Bernloehr, A., van Limbeek, E., Lalor, J. and Begley, C. (2015) 'Women-centred interventions to increase vaginal birth after caesarean section (VBAC): A systematic review', Midwifery, 31(7), pp. 657-663. November 2018. Available www.europeristat.com

Panda, S., Begley, C. and Daly, D. (2018) 'Correction: Clinicians' views of factors influencing decision-making for caesarean section: A systematic review and metasynthesis of qualitative, quantitative and mixed methods studies', *PloS one,* 13(8), pp. e0202688.

Panda, S., Daly, D., Begley, C., Karlström, A., Larsson, B., Bäck, L. and Hildingsson, I., (2018). Factors influencing decision-making for caesarean section in Sweden–a qualitative study. *BMC pregnancy and childbirth*, *18*(1), pp.1-8.

Penrod, J. (2001) 'Refinement of the concept of uncertainty', *Journal of Advanced Nursing,* 34(2), pp. 238-245.

Preis, H. and Benyamini, Y. (2017) 'The birth beliefs scale – a new measure to assess basic beliefs about birth', *Journal of Psychosomatic Obstetrics & Gynecology,* 38(1), pp. 73-80.

Preis, H., Chen, R., Eisner, M., Pardo, J., Peled, Y., Wiznitzer, A. and Benyamini, Y. (2018) 'Testing a biopsychosocial model of the basic birth beliefs', *Birth,* 45(1), pp. 79-87.

RCOG (2015) *Birth After Previous Caesarean Birth.* UK. https://www.rcog.org.uk/globalassets/documents/guidelines/gtg_45.pdf

Reyna, V. F. (2008) 'A Theory of Medical Decision Making and Health: Fuzzy Trace Theory', *Medical Decision Making,* 28(6), pp. 850-865.

Ryding, E. L., Lukasse, M., Parys, A.-S. V., Wangel, A.-M., Karro, H., Kristjansdottir, H., Schroll, A.-M., Schei, B. and the Bidens, G. (2015) 'Fear of Childbirth and Risk of Cesarean Delivery: A Cohort Study in Six European Countries', *Birth,* 42(1), pp. 48-55.

Shorten, A. and Shorten, B. (2012) 'The Importance of Mode of Birth After Previous Cesarean: Success, Satisfaction, and Postnatal Health', *Journal of Midwifery & Women's Health,* 57(2), pp. 126-132 7p.

Shorten, A. and Shorten, B. (2014) 'Timing the provision of a pregnancy decision-aid: temporal patterns of preference for mode of birth during pregnancy', *Patient Educ Couns,* 97(1), pp. 108-13.

Shorten, A., Shorten, B., Keogh, J., West, S. and Morris, J. (2005) 'Making choices for childbirth: a randomized controlled trial of a decision-aid for informed birth after cesarean', *Birth: Issues in Perinatal Care,* 32(4), pp. 252-261.

Stiggelbout, A. M., Pieterse, A. H. and de Haes, J. C. J. M. (2015) 'Shared decision making: Concepts, evidence, and practice', *Patient education and counseling,* 98(10), pp. 1172-1179.

Strauss, A. L. and Corbin, J. M. (1998) *Basics of qualitative research : techniques and procedures for developing grounded theory.* 2nd edn. Thousand Oaks, Calif.: Sage.

Symon, A. (2006) *Risk and choice in maternity care : an international perspective.* Edinburgh: Churchill Livingstone Elsevier.

Thomson, G. and Downe, S. (2013) 'A hero's tale of childbirth', *Midwifery,* 29(7), pp. 765-771.

Thomson, G. and Downe, S. (2016) 'Emotions and support needs following a distressing birth: Scoping study with pregnant multigravida women in North-West England', *Midwifery,* 40, pp. 32-39.

Thomson, G. M. and Downe, S. (2010) 'Changing the future to change the past: women's experiences of a positive birth following a traumatic birth experience', *Journal of Reproductive and Infant Psychology,* 28(1), pp. 102.

Tolmacheva, L. (2015) 'Vaginal birth after caesarean or elective caesarean--What factors influence women's decisions?', *British Journal of Midwifery,* 23(7), pp. 470-495.

WHO (2015) *WHO statement on caesarean section rate*.

Wise, M. R., Sadler, L., Shorten, B., van der Westhuizen, K. and Shorten, A. (2019) 'Birth choices for women in a 'Positive Birth after Caesarean' clinic: Randomised trial of alternative shared decision support strategies', *Australian & New Zealand journal of obstetrics & gynaecology,* 59(5), pp. 684-692.

Witt, J., Elwyn, G., Wood, F. and Brain, K. (2012) 'Decision making and coping in healthcare: The Coping in Deliberation (CODE) framework', *Patient Education & Counseling,* 88(2), pp. 256-261.

Wu, Y., Kataria, Y., Wang, Z., Ming, W.K. and Ellervik, C., (2019). Factors associated with successful vaginal birth after a cesarean section: a systematic review and meta-analysis. *BMC pregnancy and childbirth*, *19*(1), pp.1-12