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Women's Self-Transcendence Levels after a Cesarean Birth and its Contributing Variables

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ABSTRACT

Background: A Cesarean birth has significant implications for women's physical and psychological health. However, limited studies have explored self-transcendence, as a measure of well-being, and its contributing variables during the postpartum period. ***Purpose*:** This study aimed to determine the levels of self-transcendence among women after a Cesarean birth and to explore the contribution of demographic and obstetric variables. ***Methods*:** This descriptive correlational study used a convenient sample of 232 women (aged 19-49 years) who completed questionnaires in teaching and private hospitals. ***Results*:** Overall, 55% (n=128) of women had high levels of self-transcendence, with a mean score of 45.8 (SD=6.1) out of 60. Self-transcendence was negatively correlated with the number of Cesarean births ($r= -0.21$, $p < 0.001$). Higher self-transcendence levels were found among women who gave birth at private hospitals ($rpb= 0.41$, $p < 0.001$). ***Conclusion*:** A Cesarean birth can be an opportunity for self-transcendence and psychological well-being for women, depending on demographic and obstetric variables. ***Implications for Nursing*:** The findings of this study may inform healthcare professionals, especially maternity nurses, in understanding psychological dimensions associated with Cesarean birth.

Keywords: Cesarean birth, Jordan, Obstetrics, Self-transcendence.

What does this paper add?

1. This study provides preliminary insights into women's self-transcendence levels after a Cesarean birth and associated variables.
2. The study findings may guide health professionals in understanding the dimensions of psychological well-being after a Cesarean birth.
3. The findings of this study provide support for the premises of the Self-Transcendence Theory.

Introduction

A Cesarean birth is facilitated by a common elective or emergency obstetric procedure, which is an abdominal surgical incision known as a Cesarean section, to decrease maternal and infant morbidity and mortality (Al-Rawashdeh, et al., 2020; Angolile et al., 2023; Betran et al., 2021; Elnakib et al., 2019; Salem, 2021). Nonetheless, a Cesarean birth is recognized as a potentially traumatic event with both short-term and long-term physical and psychological complications (Elnakib et al., 2019; Huang et al., 2019; Larsson et al., 2021; Osayande et al., 2023; Salem, 2021; Sobhy et al., 2019).

Genuine global concerns for women's physical and psychological well-being after a Cesarean birth are superimposed by accumulated evidence regarding the increasing rates of Cesarean birth worldwide. Reports show that Cesarean births account for 21% of all childbirths,

exceeding the recommended World Health Organization (WHO) rate of 10%-15% (Betran et al., 2021; WHO, 2021). Global rates are expected to rise, where 29% of all births are projected to occur through a Cesarean birth by 2030 (WHO, 2021). In Jordan, Cesarean birth rates range from 27% to 31% (Al-Rawashdeh et al., 2022; Salem, 2021). The most common indications include previous Cesarean births, fetal malpresentation, and maternal request (Salem, 2021).

Literature reviews and meta-analyses identify Cesarean birth as one of the leading risk factors associated with lower health-related quality of life, decreased satisfaction, increased risk of psychological disorders, and negative life experiences (Benton et al., 2019; Jenabi et al., 2020; Mascarello et al., 2017; Osayande et al., 2023; Zhao & Zhang, 2020). Women who have Cesarean births are a specifically vulnerable postpartum population. Research indicates that women who have Cesarean births are more vulnerable than women who have vaginal births to the risks of postpartum mental disorders, psychological maladjustment (i.e., depression, anxiety), impaired mother-infant relationship, and compromised emotional and mental well-being (Benton et al., 2019; Dekel et al., 2019; Huang et al., 2019; Sun et al., 2021). Given the negative effects of Cesarean birth on women's well-being and the continuous rise in global rates, there is a need to support women's well-being after Cesarean births.

In her Self-Transcendence Theory (STT), Reed viewed self-transcendence as the expansion of personal boundaries and a sense of purpose beyond the self, which offers a promising framework for enhancing well-being (Reed, 2014, 2018). The STT encompasses three major concepts: vulnerability, self-transcendence, and well-being. A major premise of the STT emphasizes the role of self-transcendence as a mediator between vulnerability and well-being that is directly and positively related to a sense of well-being, healing, and personal growth (Reed, 2014, 2018). Self-transcendence is also viewed as a component of maturity and wisdom that involves innate processes of developmental ability to move beyond self-centered consciousness towards embracing greater awareness and broader life perspectives, activities, and purposes (Reed, 2014, 2018). Moreover, self-transcendence embodies a fluctuation of perceived boundaries that extend the person (or self) beyond the immediate and constricted views of the self and the world. This fluctuation is pandimensional with several dimensions: outward (toward others and the environment), inward (toward greater awareness of one's own beliefs, values, and dreams), and temporal (toward integration of past and future in a way that enhances the relative present) (Reed, 2014, 2018). Thus, self-transcendence has emerged as a novel approach that can be adopted by maternity nurses to enhance well-being and adjustment to adversity among vulnerable populations (Reed, 2014, 2018). Maternity nurses may draw on self-transcendence as a source to empower women, assist in healthy adaptation, and maximize well-being after a Cesarean birth. Therefore, integrating holistic healthcare strategies and approaches including sharing personal experiences, peer support groups, mindfulness, psychotherapy, prayer and spiritual activities can enhance women's well-being after a Cesarean birth (Reed & Haugan, 2021). However, there are limited studies exploring self-transcendence levels, processes, and determinants in the context of reproductive health, specifically after a Cesarean birth. In this study, we aimed to measure the levels of self-transcendence among women who had Cesarean births and to explore the contribution of demographic and obstetric variables.

Methods

Study Design

A descriptive, correlational design was applied.

Sample

Women, 18 years or older, who had a Cesarean birth, and free of significant physical or mental illnesses were eligible to participate in this study. The minimum target sample size for this study was 103 participants, as required to provide 80% power for detecting 0.15 effect size on a linear multiple regression analysis, adjusting for seven independent variables. An alpha level of 0.05 or less was considered significant. The sample size was estimated using G*Power (version 3.1.10) software (Faul et al., 2007). Convenience sampling was followed to enroll the participants and the final sample consisted of 232 women.

Settings

The selected study settings were obstetric and pediatric clinics at three facilities including a teaching hospital (JUH, 550 beds), and two private hospitals (Ibn-Alhaytham, 230 beds and Alislami, 423 beds). All

settings are located in Amman and have high labor and delivery turnover rates as well as obstetric healthcare service utilization.

Measurements

A multi-scale self-administered questionnaire was used to measure demographic and obstetric data as well as the level of self-transcendence. Demographic data included participants' age, family income, educational level, newborn's biological sex, education, occupation, socio-economic status, and smoking. Obstetric data included type of Cesarean birth, history of previous Cesarean births, indication, and type of setting. The level of self-transcendence was measured using the Self-Transcendence Scale (STS), which is based on the Self-Transcendence Theory (Reed, 2014, 2018). The STS is a one-dimensional scale, consisting of 15 items that together identify characteristics of a matured view of life that expand the boundaries of the self. The scale reflects participants' overall matured perceptions of life that expand the self-boundaries. Responses are measured using a 4-point Likert scale (from 1 = not at all to 4 = very much). The total score ranges between 15 and 60, where higher scores indicate greater self-transcendence levels, reflecting enhanced adaptation to vulnerability after Cesarean birth, enhanced personal maturity, and sense of mental and emotional well-being. Generally, a score of 15-30 indicates a low level of self-transcendence; a score of 31-45 indicates a moderate level; and a score 46-60 indicates a high level (Reed, 2014, 2018). The scale demonstrated very good reliability and validity indicators in previous studies, among diverse populations, and different languages (Bovero et al., 2023; Elkady et al., 2019; Haugan et al., 2022). Adaptation of the STS involved rigorous measures to translate and back-translate the items into the Arabic language. The process involved tool translation and linguistic evaluation by three bilingual field experts. Further evaluation for content validity was performed by five maternity nursing academics. The Arabic version of the STS was pilot tested, resulting in minor wording modification on item 15 of the scale "I can let go of what once caused regret" and showed a marginally acceptable reliability (Cronbach's $\alpha = 0.69$).

Ethical Considerations

Ethical approvals for the study were obtained from the University of Jordan Institutional Review Board (#121/2017-2018) and Ministry of Health. Participants received a standardized information form outlining the study purpose, potential risks, and their rights, including voluntary participation, anonymity, confidentiality of data, and the assurance that declining participation would not affect their healthcare. Written informed consent was obtained from all participants. Completed questionnaires and relevant study materials were stored in a secured cabinet. Electronic files were stored in a password-protected computer accessible only to the primary investigator.

Data Collection

Data collection was facilitated by three registered nurses who were trained as research assistants regarding ethical conduct of research and data collection methods. In each setting, research assistants collaborated with the clinic nurses to identify and access eligible participants who had a Cesarean birth within the last 12 weeks. Research assistants invited women coming to clinics for check-ups and/or immunizations for their children to participate in the study. After consent, participants were given the questionnaire to complete. All participants returned the completed questionnaires to the research assistants directly. Data collection occurred over the period between November, 2019 and February, 2020.

Data Analysis

Descriptive and inferential statistics were used to describe and explore STS scores and associated demographic and obstetric variables. A multiple regression (entry) analysis at 95% confidence level was performed to evaluate whether the women's demographic and obstetric variables contributed to the STS scores. Assumptions of multiple regression including linearity, normality, homoscedasticity, and multi-collinearity were verified prior to analysis (Polit & Beck, 2022). Analyses of variance, Pearson's rho, and point-biserial correlation were additionally performed to gain further insight into the associations between STS scores and selected demographic and obstetric variables. An alpha of ≤ 0.05 was selected as the statistical significance level. Data analyses were performed using the Statistical Package for Social Sciences (SPSS) for Widows, version 25.

Results

Sample Characteristics

Participants' characteristics are detailed in Table 1.

Participants' age ranged from 19 years to 49 years (M=31.45, SD = 5.72). The level of education ranged from secondary to graduate education, where 53.9% (n=125) of the participants had a bachelor's degrees. Almost two thirds of the participants (n=140, 60.3%) had an average monthly family income of 800 JDs or less, 56.9% were unemployed (n=132), and 83.2 % (n=193) reported that their income barely to moderately covered their family needs. The majority of the participants reported not smoking (n=217, 93.5%).

Table 1. Sample characteristics (n=232)

Variable		N	%
Age (Year)			
	≤ 19	2	0.9
	20-29	84	36.2
	30-39	131	56.5
	40-49	15	6.5
Educational Level			
	Secondary school	15	6.5
	High school	40	17.2
	Diploma degree	37	15.9
	Baccalaureate degree	125	53.9
	Master degree	12	5.2
	PhD degree	3	1.3
Employment			
	Yes	100	43.1
	No	132	56.9
Monthly Family Income (JDs)*			
	≤ 800	140	60.3
	801-1500	78	33.6
	1501-2500	11	4.7
	≥ 2500	3	1.3
Description of Income			
	Covers needs to a great extent	10	4.3
	Covers needs to a moderate extent	107	46.1
	Barely covers needs	86	37.1
	Does not cover needs	29	12.5
Smoker			
	Yes	15	6.5
	No	217	93.5
Type of Cesarean Birth			
	Emergency	162	69.8
	Elective	70	30.2
Number of Cesarean Births			
	First time	106	45.6
	Second time or more	126	54.4
Newborn's Sex			
	Female	99	42.7
	Male	133	57.3
Birth Setting Type			
	Teaching	153	65.9
	Private	79	34.1
Indication for Cesarean Birth			
	Fetal compromise	88	37.9
	Previous C/S	54	23.3
	Dystocia	37	15.9
	Fetal malposition	24	10.3
	Twins	16	6.9
	Other (IVF, placenta previa, postterm)	13	5.6

* poverty line ≤ 800 JD.

Some participants had two or more Cesarean births (n=26, 54.4%), had emergency Cesarean births (n=162, 69.8%), and had male offspring (n=129, 55.6%). The frequency of emergency Cesarean births ranged between once and six times. The most commonly reported reasons for Cesarean births were fetal compromise (n=88, 37.9%) and a previous Cesarean birth (n=54, 23.3%).

Self-Transcendence Level

Self-transcendence overall scores ranged from 28 to 59, with an average score of 45.8 (SD=6.1) out of 60. More than a half of the participants (n=128, 55 %) had high levels of self-transcendence (Table 2). The STS highest response mean score was on the item "I found a meaning in my spiritual beliefs." (M=3.68 SD=0.64), while the lowest response mean score was on the item "I have hobbies or interests that I can enjoy" (M=1.90 SD=0.97) (Table 3).

Table 2. Self-Transcendence level distribution frequencies and percentages

Score	N	%
15-30 (Low)	1	0.4
31-45 (Moderate)	103	44.39
46-60 (High)	128	55.17

Table 3. Self-Transcendence scale item means and standard deviations

Item	M	SD
I have hobbies or interests that I can enjoy	1.90	0.97
I can accept myself as I get older	3.48	0.75
I have the ability to share with others or my society when possible	2.79	1.08
I pretty good can adapt to my current life	3.25	0.75
I am capable of adjusting to changes in my physical abilities	2.92	0.88
I am capable of sharing my wisdom or experience with others	3.36	0.97
I can find meaning in my previous experiences	3.57	0.76
I somehow help others	3.04	1.01
I am continuously interested in learning	2.65	1.20
I can overcome some issues that once were very important to me	3.03	0.94
I accept death as a part of life	3.16	0.97
I found a meaning in my spiritual beliefs	3.68	0.64
I allow others to help me when I need help	3.24	0.83
I am enjoying my pace of life	3.03	0.89
I can let go of what once caused regret	2.76	1.14

Demographic and Obstetric Variables' Contribution to Self-Transcendence Level

The overall multiple linear regression model was significant ($F(215) = 7.477$, $p=0.00$) for the following variables' contribution to the self-transcendence level: women's age, income, employment, newborn's gender, smoking, number of previous Cesarean births, and birth setting type. The model explained approximately 17% of the variance in self-transcendence scores among participants, possibly indicating data homogeneity where most participant responses on the STS scale indicated moderate and high self-transcendence levels. Only the two obstetric variables, which are number of previous Cesarean births ($\beta = -0.150$, $p = 0.022$) and birth setting type ($\beta = 0.396$, $p < 0.001$) significantly contributed to self-transcendence scores. None of the five selected demographic variables in this study were statistically significant, indicating the need to explore additional key variables that could predict self-transcendence scores (Table 4).

Table 4. Multiple linear regression analysis

Model	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	**Std. Error**		**Beta**	
(Constant)	42.452	3.690		11.504	0.000
Age (years)	0.011	0.070	0.010	0.150	0.881
Level of Education	0.396	0.373	0.069	1.062	0.289
Monthly Income	-0.084	0.602	-0.009	-0.140	0.889
Newborns' Sex	-0.057	0.665	-0.005	-0.085	0.932
Smoking	-0.480	1.542	-0.019	-0.311	0.756
Number of Cesarean Births	-0.861	0.374	-0.150	-2.302	0.022*
Type of Birth Setting	30.036	0.498	0.396	6.101	0.000*
R^2	0.173				
Adjusted R^2	0.146				

***** $p \leq 0.05$.

Analysis of variance showed a significant difference (F=23.6, p=00) on self-transcendence mean scores between teaching (M=44.1, SD=5.28) and private hospitals (M1=48.2, SD=7.29; M2=50.2, SD=4.78). A moderate positive relationship was indicated by point-biserial correlation between the type of birth setting and self-transcendence scores (pbr=0.40, p=0.00). A significant weak negative correlation was found between number of previous Cesarean births and self-transcendence scores (r= -0.20, p=0.00).

Discussion

The aim of this study was to measure the levels of self-transcendence among women who had Cesarean births and to explore the contribution of demographic and obstetric variables. Hence, this study provided preliminary insights into the understudied phenomenon of self-transcendence among women after Cesarean births. The findings of this study supported the notion that Cesarean birth may represent an opportunity for personal development and maturity through transcendence over adverse physical and psychological dimensions (Reed, 2014, 2018). The findings are congruent with previous studies on self-transcendence in other vulnerable populations, such as nursing home residents, patients with cancer, and retirees (Benton et al., 2019; Haugan et al., 2022; Mascarello et al., 2017; Zhao & Zhang, 2020).

In this study, selected demographic and obstetric variables were conceptually rooted in Reed's Self-Transcendence Theory, and emphasizing the role of vulnerability and contextual variables in facilitating or hindering self-transcendence. For example, repeated Cesarean births may increase vulnerability, while supportive birth settings may enhance outward transcendence. The majority of women in this study had emergency Cesarean birth experiences, and had previous Cesarean birth experiences which are associated with tremendous perinatal distress and vulnerability, in the absence of pre-existing medical issues. The findings highlight the mediating impact of self-transcendence on vulnerability, where reported moderate to high levels of self-transcendence indicate health adjustment, resilience, well-being, and developmental maturity that is rooted in cultural spiritual values and beliefs (e.g. acknowledging God's will, acceptance of fate, having gratitude) in dealing with a Cesarean birth as a traumatic life event (Baig & Isgandarova, 2023; Betran et al., 2021; Elkady, 2019; Reed, 2014, 2018; Reed & Haugan, 2021; Sun et al., 2021).

The findings also showed a weak, inverse relationship between self-transcendence and the number of Cesarean births, despite the fact that self-transcendence scores were high, indicating that not all selected variables significantly contributed to the differences in scores on the STS among the participants. A possible explanation for this finding is that repeated Cesarean births represent increased potential risks and complications that can potentially lead to a decreased sense of well-being in the long run, possibly eluding to the dynamic nature of self-transcendence. This finding provides initial support for the premise of influence of the temporal dimension (integration of past and future in a way that enhances the relative present) on self-transcendence (Reed, 2014, 2018). However, given the paucity of available evidence, future research in this area is required.

A significant moderate positive correlation was found between type of hospital and self-transcendence. The relationship between birth setting and the level of self-transcendence is not well-documented in the literature. In this study, higher self-transcendence scores were found among women undergoing Cesarean births in private hospitals. The difference in mean scores of self-transcendence according to birth setting may indicate that a private hospital environment with increased autonomy, attentive perinatal health services, and a supportive holistic care approach can help promote a sense of well-being among women after a Cesarean birth. This finding is congruent with the premise of the influence of the outward dimension (others and the environment) on self-transcendence (Reed, 2014, 2018; Reed & Haugan, 2021). However, preliminary findings in our study need further corroboration in future studies to better infer the cause-effect relationship between birth-setting characteristics, healthcare providers' support, and self-transcendence levels.

The use of self-report instruments, the recruitment of a convenient sample, and settings restricted to one region are major limitations of this study that may limit the generalizability of its findings.

Implications for Nursing

The findings of this study may serve as a guide for healthcare professionals, especially maternity nurses, in understanding psychological dimensions of Cesarean birth and designing holistic interventions (e.g. peer support groups, mindfulness, psychotherapy, prayer and spiritual activities) and counseling aimed at improving women's psychological well-being. The findings of this study provide preliminary support for the premises of the Self-Transcendence Theory and further studies are recommended using more representative, culturally-diverse samples, diverse settings, and various research designs. Qualitative studies may be valuable in further exploring the inner processes that women with Cesarean birth use to balance between vulnerability and well-being. The authors recommend future comparative studies on self-transcendence levels between women with Cesarean births and those with normal vaginal births; assessing differences in self-transcendence levels among women with Cesarean births of live newborns after a pregnancy loss; and exploring longitudinal change in self-transcendence levels in women who have repeated Cesarean births compared to those with the first Cesarean birth.

Conclusion

Healthcare professionals should consider women's well-being beyond the physiological aspects and consider the psychological, emotional, and spiritual dimensions that take prominence in a Cesarean birth. Although a Cesarean birth is considered traumatic, especially an emergency one, it can be an opportunity for self-transcendence for women. Cesarean birth can be a time for developmental maturity, personal growth, and wisdom. The results of this study implicate the need to focus on monitoring and addressing self-transcendence as one of the women's adjustment strategies and innate abilities to adapt and overcome physiological and psychological outcomes of Cesarean birth. Healthcare professionals should further implement supportive and educative roles regarding enhancing the women sense of well-being and self-transcendene.

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Data Availability

Research data of this study is not publically available.

Conflict of Interests

The authors have no conflict of interests to declare regarding this study.

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