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ACTA Obstetricia et Gynecologica Scandinavica

AOGS COMMENTARY

What is underneath the cesarean request?

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Key words
Fear of childbirth, counseling services, cesarean section, childbirth experience

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Conflict of interest
The authors alone are responsible for the content and writing of this paper. The authors report no conflicts of interest.

Please cite this article as: D. Dweik, A.M. Sluijs. What is underneath the cesarean request? Acta Obstet Gynecol Scand 2015; 94: 1153–1155.

Received: 27 May 2015
Accepted: 9 June 2015

DOI: 10.1111/aogs.12692

Abstract

In the Nordic countries, where there is a real pursuit to keep cesarean section rates at a relatively low level, the efforts to align maternity care to the needs of women reflect a unique approach among high-income countries. Electively performed cesarean section due to fear of childbirth is one example of this increased attention. The antenatal counseling services' primary aim is the promotion of a positive childbirth experience, regardless of mode of delivery. It is very likely, however, that even a fulfilled request for cesarean section is not enough to ensure a positive birth experience. Therefore, a maternal request for cesarean delivery should first be interpreted as a sign of increased maternal vulnerability rather than a need that should be met unconditionally.

Abbreviation: CS, cesarean section; FOC, fear of childbirth.

Introduction

Why do cesarean section (CS) rates show a rising tendency in almost all parts of the world? What should and what could be done to stop this escalation? These are seemingly simple questions, but with a large variety of answers, depending on who is being asked and in which country (1). Many of the latest studies on birth preferences, childbirth fear and cesarean delivery on maternal request call attention to the context in which maternity care is provided (2,3). Not only is different cultural conceptualization of childbirth reflected in different maternity care policies (4), but also the dominant practice of maternity care has an influence on the interpretation of childbirth, as regards both women and their care providers (3). Efforts in the Nordic countries to suit maternity care to the needs of women are indicative of a unique approach among the high-income countries. Although CS rates in the Nordic countries are among the lowest seen in high-income countries, Nordic researchers seem to be very concerned about keeping CS rates at a reasonable level (5). Research activity on these issues certifies that they feel responsible for not just providing explanations for the rising CS rates, but also for acting against this rise. They aim to act before these countries experience what a World Health Organization report in 2010 described as "cesarean sections that are possibly, in the large majority at least, medically unnecessary", but that "appear to command a disproportionate share of global economic resources" (6).

Is counseling effective?

A good example of scientific devotion to this field can be seen in the recent article by Larsson et al. in this journal (7), who called attention to the need for better means of handling the care of pregnant women who express either a wish for an elective CS or a fear of childbirth (FOC).

The article reflects an overall need for a more effective, evidence-based and uniform screening and counseling system in Sweden. The authors point to an ever growing number of publications which need to be summarized by experts and converted to national guidelines on how to handle CS requests based on FOC. Larsson et al. (7) listed the most important measures in the process of counseling. Through these, further progress could be attained within the unique system that already exists in Sweden. First, there is a need for more effective screening for childbirth-related fear that would reach each affected woman. But a second aim is that the counseling system should not be "misused" by those women who wish to deliver abdominally. Women whose wish is an expression of something other than pathologic FOC. Awareness of such inappropriate requests is an important issue, which if handled well, would serve to enhance the efficacy of the counseling process. Larsson et al. question the "raison d'être" of a counseling service aimed at women with FOC, but which does not have a statistically significant impact on women's FOC nor on their determination to deliver by elective CS, or of a service which cannot modify the experience of childbirth. Among possible targets for a national guideline they highlight strengthening the self-efficacy that pregnant women need to develop. Furthermore, they point out that the majority of women with a preference for CS are parous, i.e. women who had gone through CS previously, and that very few women who had previously delivered vaginally needed counseling for FOC in their next pregnancy (7). Hence, avoiding the first abdominal delivery is of extreme importance.

Waldenström et al. (8) have highlighted the two extremes of outcome among women with FOC. Those who went through counseling had an "acceptable" birth experience but were more likely to have delivered by elective CS, whereas women who had not received counseling, had a more negative experience of birth. This unveils an exciting question regarding research on FOC, namely what should be the end-point of the interventions that target women with FOC? Should it be the change in childbirth preference, or a significant decrease of scores reached on a FOC-scale? Should it be their positive birth experience or better functioning as a mother, irrespective of delivery mode? Or should all four outcomes be taken into account when estimating the effectiveness of counseling?

Will cesarean section satisfy all who have it?

A very important aspect of childbirth experience was highlighted by Karlström et al. (9). Women who prenatally wished for and subsequently delivered by elective CS tended to be more negative in assessing almost the whole process of maternity care (from antenatal care to birth experience), compared with women who preferred vaginal delivery and delivered that way. This implies that, in contrast to what one might expect, even a fulfilled request for CS is not enough to ensure a positive birth experience. If the counseling services' primary aim is to enhance this experience (regardless of mode of delivery), this means that performing an elective CS is by no means the right answer to a maternal request for one. The liberal approach that "respects" the autonomy of these women might be the most convenient way of handling this issue on behalf of the healthcare personnel (10); however, these women are virtually left alone, both mentally and physically. Therefore, it is likely that the right interpretation of a maternal request for CS is a "cry for help".

There is evidence that objective circumstances by themselves cannot be blamed for an unpleasant childbirth experience or for the development of secondary FOC. Although Størksen et al. (11) found a significant association between previous delivery complications (especially emergency CS or instrumental vaginal delivery) and development of a subsequent negative birth experience during the next pregnancy among Norwegian parous women, they emphasized that more than three-quarters of women who had at least one obstetric complication during the previous delivery had neither developed FOC nor did they recall a negative birth experience during the next pregnancy. They highlighted the importance of a subjective appraisal of labor and delivery. Sluijs et al. (12) showed on a low-risk sample of Dutch women that higher levels of FOC persisted after delivery, irrespective of obstetric complications. The prepartum level of FOC predicts how threateningly the woman will appraise the situation during labor. Women experience what they are afraid of beforehand, which will influence their postpartum FOC level (13,14). Lukasse et al. (15) showed, on a non-selected population of Norwegian women, that more second-time mothers, who reported having been abused in childhood, recalled a "worse than expected" experience of their first childbirth, compared with women who did not have such memories. It is important to highlight that there was no difference between the two groups of women with regard to mode of their first delivery. They concluded that even parous women's FOC and preference for CS in a second pregnancy can be associated with childhood abuse. These studies suggest that there must be an increased vulnerability (possibly related to childhood abuse) that makes certain women experience an "average" delivery in a negative way. But if there is increased maternal vulnerability or sensitivity in the background, then this also deserves increased psychological attention from early pregnancy onwards and into the months after

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delivery. Compared with such enhanced prophylactic attention, electively performed CS on its own can only be an insufficient solution.

Conclusion

As several studies have shown, maternity care in medically dominated cultures is disabled by organizational, economic and legislative aspects, which seem to be much more important factors than the individual woman's needs. In parts of the world where such attitudes prevail, the delivery rooms have, in an allegorical sense, turned into battlefields of solicitors and physicians, where there remains not much room for women to express their fear or happiness. In the Nordic countries where there is a real pursuit to keep CS rates at a relatively low level and maternity care is not paralyzed by the above-mentioned burdens, women's feelings, wishes, preferences and fears can remain in the focus of maternity care. The counseling system might be too liberal and therefore it could attract women who request CS for other reasons than FOC alone. We believe, however, that this is of minor importance compared with the relief for women when they feel that they are being supported and listened to. In the long run, a positive birth experience, next to a healthy mother and child, should always be the most important goal of antenatal services, because it will be conducive to lowering FOC and it will give a strong start to the life of the mother who has just delivered and so acquired the new "identity" of motherhood. That her newborn child will benefit, is also a plausible assumption.

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