Midwifery 29 (2013) 447–452

Contents lists available at SciVerse ScienceDirect

Midwifery

journal homepage: www.elsevier.com/midw

First-time mothers' wish for a planned caesarean section: Deeply rooted emotions

M. Sahlin, RNM (PhD student)[a,*], A.-K. Carlander-Klint, RNM (PhD student)[a], I. Hildingsson, RNM, PhD (Professor)[b], I. Wiklund, RNM, PhD (Senior Lecturer)[a]

[a] Department of Clinical Sciences, Division of Obstetrics and Gynaecology, Danderyd Hospital, Karolinska Institute, Stockholm, Sweden
[b] Mid Sweden University, Department of Health Science, Sweden

ARTICLE INFO

Article history:
Received 15 March 2011
Received in revised form
23 February 2012
Accepted 27 February 2012

Keywords:
Caesarean section
Own request
Mode of delivery

ABSTRACT

Background: international estimates suggest that caesarean section on maternal request range from 4% to 18% of all caesarean section. An increasing number of surveys have investigated women's reasons for a caesarean section in the absence of a medical indication but few studies have solely studied first-time mothers motivation for this request.
Objective: to describe the underlying reasons for the desire for a caesarean section in the absence of medical indication in pregnant first-time mothers.
Method: a qualitative descriptive study, with content analysis of interviews with 12 first-time mothers.
Findings: the overarching theme formulated to illustrate the central interpreted meaning of the underlying desire for a planned caesarean section was based on deeply rooted emotions'. Four categories were identified as related to the request for a caesarean section on maternal request. The categories was identified as 'always knowing that there are no other options than a caesarean section', 'caesarean section as a more controlled and safe way of having a baby', own negative experiences of health care and having problems dealing with other people's reaction about their mode of delivery.
Conclusion: the results show that for these first-time mothers deeply rooted emotions described as stronger than fear of birth were behind their wish for a planned caesarean section.

Introduction

In many parts of the world there is an increasing rate in the proportion of caesarean sections (Swedish National Board of Health and Welfare, 2005). Although unevenly distributed the global occurrence is around 15% with developed countries reporting a 21.1% incidence (Betrán et al., 2007). There has been a strong increase in caesarean section rates in Sweden during the last decades. Between 1991 and 2008 the caesarean section rate in Sweden increased by 58%. The caesarean section rate in Sweden 2009 was over 17% with regional variations between 10% and 23% (Swedish National Board of Health and Welfare, 2010). One reason for the growing caesarean section rate is women's request for caesarean section in the absence of medical indication. International estimates on maternal request range from 4% to 18% of all caesarean section (National Institute of Health, 2006). In a study from a tertiary hospital in Sweden it was found that the dominant indication for caesarean delivery in 2005 was a psychosocial indication defined as maternal request (Stjernholm et al., 2010). Other researchers report that there is little evidence that caesarean births are gaining cultural acceptance among first-time mothers (Kingdon et al., 2006). In the Swedish Medical Birth Register, caesarean section on maternal request has no precise diagnosis, it is covered in the diagnostic code for caesarean section for psychosocial indication (code 0828). A slight underestimation is built into the system because the diagnostic setting is inconsistent and difficult to interpret. However, this code was the diagnostic code that increased the most with 80%, from years 1990 to 2001 suggesting that women's preferences do have an impact on the caesarean section rates in Sweden (Swedish National Board of Health and Welfare, 2010). Stockholm, the capital city, was the area that had the main increasing rate (Karlström et al., 2010).

Some known factors contributing to the demand for a caesarean section without medical indication is maternal age over 35 years, previous experience of elective or emergency caesarean section, a previous negative birth experience, a complicated pregnancy or childbirth fear (Wiklund et al., 2006). It has also proven to be a relationship between socio-economic factors such as unemployment, smoking and ethnic background (Hildingsson et al., 2002; Joseph et al., 2003; Waldenström et al., 2006; Wiklund et al., 2006). It has been described that this group of

* Corresponding author.
E-mail address: maria.sahlin@ki.se (M. Sahlin).

0266-6138/$ - see front matter © 2012 Elsevier Ltd. All rights reserved.
http://dx.doi.org/10.1016/j.midw.2012.02.009

women differs to some extent in their personality from women planning a vaginal delivery (Wiklund et al., 2006).

In a qualitative study from Australia the authors found that the main reasons for requiring a caesarean section were childbirth fear, issues of control and safety, and a devaluing of the female body and birth process. The women perceived that medical discourses supported and reinforced their decision as a 'safe' and 'responsible' choice (Fenwick et al., 2010). In a study from Sweden it was found that mothers requesting a caesarean section had more negative expectations of a vaginal delivery but did not always suffer from clinically significant fear of childbirth (Wiklund et al., 2008).

An increasing number of surveys have investigate women's reason for a caesarean section in the absence of a medical indication, but few studies have solely studied first-time mothers and what it is that motivates their wish for a surgical birth. In a systematic review of nulliparous women's views of planned caesarean delivery, researchers concluded that qualitative research investigating the influence both of obstetrical and psychosocial factors on women's views of vaginal and caesarean birth is required (Kingdon et al., 2006). The aim of this study was to describe the underlying reasons for the desire for a caesarean section in the absence of medical indication in pregnant first-time mothers.

Swedish birth context

In Sweden the midwife is responsible for the woman throughout her sexual and reproductive life. Antenatal care, labour, birth and the postnatal period are provided by the midwife as the primary caregiver. Midwives are responsible for the uncomplicated cases and work in collaboration with obstetricians if complications occur. Formally, caesarean section is not an option women can choose themselves. A prerequisite for a woman to get through her request for a caesarian section without medical reasons is that she clearly indicates the reasons for her request since there is no right to require a surgical operation in Sweden. If a healthy woman requests a planned caesarean section without medical indication, she is referred to an obstetric counsellor of the nearest hospital. There she will talk to a specialist (obstetrician) who is to decide upon her request. The woman is recommended to receive counselling with a midwife at a reception for women with childbirth fear. It has been clinically proven to be difficult to deny these patients a planned caesarean section. Studies undertaken by Swedish obstetricians and midwives have shown that both midwives and obstetricians considered the management of caesarean section on maternal request difficult, findings showing that they balanced between resistance and respect (Karlström et al., 2009). A way to facilitate the work around this issue was to publish a national guideline called 'National medical indications for caesarean section on maternal request' (Report 2011:09 the collaborative project of national medical indications). It acknowledged that it is relevant in meeting a woman's desire for a caesarean section given that some conditions are met. It is patient-related conditions such as; the woman presents her reasons for caesarean section and that she stands by her desire for caesarean even after she had been informed about the surgery and its risks. She must also have gone through or been offered a support call.

The care process-related conditions are about the importance of a structured medical history. The woman's ability to have a vaginal delivery is made based on the risk that there will be an emergency caesarean section. In addition, information of the short and long term effects of caesarean section for mother and child are given (Wiklund et al., in press, National medical indications for caesarean section on maternal request).

Method

Setting

The hospital where this study was conducted is situated in the northern part of Stockholm. Sweden, and has two labour wards with a total of 8,500 deliveries per year. The total caesarean rate in the hospital including both primiparas and multiparas was 19% in 2009.

Participants

Seventeen an invitation to visit at the obstetric department for discussion about mode of delivery. Two of them declined participation when an appointment for the interview arranged. The reason for this was lack of time. One of the participants gave birth before the interview date and two of them could not be reached by phone. Out of these seventeen remained 12 first-time mothers with normal pregnancies who were scheduled for a planned caesarean section without of medical indication. They were all physically and mentally healthy during pregnancy with an expected normal obstetric outcome. At the time for the interview the length between gestational ages varied between 26 and 36 weeks. The women were between 25 and 39 years of age and all of them were born in Sweden and they were Swedish speaking. None of them were smokers. Examples of occupations were registered nurse, Chief Executive Officer, purchasing manager, designer, guardian and project manager. All women participating in the study were living with a partner. Women were recruited at a visit at the obstetrical practice when they consulted an obstetrician in order to discuss mode of delivery. After the visit the obstetrician gave the woman brief information about the study and invited them to participate in the study after the decision about caesarean section was taken. If the woman agreed, one of the midwives in the research group phoned her providing more detailed information about the study. If still agreeable, a suitable time for the interview was organised.

Data collection

Data were collected from February 2009 to June 2010. We attempted to recruit around 20 women, 17 consented but at the time for the interview only twelve fulfilled their consent. In the process of analysis it became clear that after approximately ten interviews no new information was gathered suggesting that twelve interviews fulfilled the aim of the study. All participants were interviewed individually. The interviews lasted between 30 and 60 mins, were audio taped and transcribed into text. The interviews took place in a private room at the hospital or in the women's homes, depending on the participant wish. All interviews were conducted by two of the four midwives from the research group. The research team consisted of two postgraduate students who are midwives, one midwife with a PhD and one professor, all with midwifery education. During the interviews, the researchers kept field records to provide comments for the data analysis. At the end of the interview the researcher made a brief summary to confirm that questions asked were rightly understood. The interviews were semi-structured and based on an interview guide. The guide contented of twenty open-ended questions about thoughts and feelings concerning the woman's requests for a caesarean section. The guide included topics as follows: what are your spontaneous thoughts about your desire