Questions from Our Readers

Childbearing Women's Fears: At the Heart of "Choice"

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Abstract

In this column, the author examines how the promotion of medical birth feeds into women's natural concerns about pregnancy and birth and, consequently, negatively influences their childbirth choices.

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Question

Your last column, titled “‘Reality’ Birth: Marketing Fear to Childbearing Women” (Lothian & Grauer, 2003), made me think about the choices that the women in my childbirth classes are making about their births. I used to think women's greatest fear was the pain of labor and birth, but I now think other fears may be influencing their choices. Are fears that are well beyond the fear of pain driving the choices childbearing women make?

Answer

I think the fear of pain during childbirth is the tip of the iceberg. At the heart of women's fears is something much more powerful than fear of the pain that comes with labor and birth: the safety of the baby. Consider the typical response if a woman considers using a midwife or giving birth outside the hospital: “Aren't you brave!” is quickly followed by the questions, “What if something goes wrong?” and “How can you put your baby at risk?” (Kitzinger, 2000).

Historically, women quite rightly have feared childbirth not because of the pain, but rather the all-too-real

risks accompanying labor, birth, and the early postpartum period. These risks decreased dramatically in the last century, largely due to improved nutrition and hygiene (everyday things) and the availability of antibiotics to deal with infection (a great medical advance) (Rooks, 1997). Contrary to what women are led to believe, no evidence exists that routine hospitalization and the routine use of medical technology (including continuous electronic fetal monitoring, intravenous lines, or induction and augmentation of labor) save mothers' or babies' lives (Enkin, Keirse, Renfrew, & Neilson, 2000). Routinely caring for women as if they were high risk may actually increase the risk of things going wrong. Most women do not know this; in fact, they are told something quite different.

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Modern management of pregnancy—prenatal care that “expects trouble” (Strong, 2002)—feeds into women’s natural concerns for their growing baby. The result is escalating fear rather than reassurance. Advice from family and friends, unlike a century ago, echoes the refrain of physicians: “Things can go terribly wrong. Get the best medical care possible. Have your baby in a hospital.” Fear for the safety of the baby has reached new heights. Almost every intervention and every care practice claim to be done to avoid all possible risk. This belief has resulted in a cesarean rate that has reached 26% (Centers for Disease Control, 2003) with no improvement in infant mortality or morbidity. The results of over 30 years’ worth of research reveal that the very care practices touted to make birth safer and insure a healthy baby too often do quite the opposite (Enkin et al., 2000). In spite of this, women are continuously all but promised a healthy baby if they follow all the rules (Wagner, 1994), which include countless prenatal tests and procedures. The medical community capitalizes upon the myth that medical science can insure a healthy baby; thus, women’s fears make them willing participants in the fraud. This myth also fires the litigation

explosion and directly results in the sky-rocketing malpractice insurance fees.

What is missing in this picture is a basic, respectful understanding of the normal, natural process of pregnancy and birth. What is also missing is a confident woman who is the expert in her own pregnancy, who shares what is happening with her family, her friends, and her health care provider, and who looks to them for reassurance and support. Dutch midwives and women describe “spoiling” the pregnancy when outsiders become the experts in a woman’s pregnancy—trying to fix things or looking for things to go wrong (Rothman, 2001). The confident, happy, excited woman who finds out she is pregnant is no where in evidence by the fourth or fifth month. She is now worried and confused and, in a strange way, detached from her pregnancy. Her baby is the ultrasound picture, not what she feels within her. The health of her baby is determined by tests—the triple screen and amniocentesis—not the natural, amazing capability of her own body. Strict guidelines on eating, drinking, weight gain, and stress contribute to two, disastrous hallmarks of modern obstetrics: the lack of confidence in women’s own ability to know how to grow, birth, and mother her baby and the myth that doing everything “right,” based on expert opinion, insures perfection. It is not a surprise that she comes to childbirth class a wreck—worried about her baby and worried about labor. She will not relax until she has a healthy baby in her arms. She is seduced by the idea of induction. She thinks about planning a cesarean and avoiding labor entirely. She is confident . . . confident in her doctor and confident that modern technology will insure that her baby will be safe and healthy. She thinks that the choices she has made will achieve her ultimate goal: the safety of her baby. What she does not know is that her choices have been largely determined by fear, a fear that has been carefully cultivated. The choices she has made are far from personal choices; rather, they have been powerfully influenced by politics and economics (Kitzinger, 2000).

The care most likely to treasure her pregnancy, honor her birth, and, ultimately most effectively promote and protect her baby’s safety is the care that, because of politics and economics, she is not likely to choose: midwifery care and out-of-hospital birth. She has been told over and over in a thousand different ways that the health and safety of her baby depend on physicians and

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hospitals, tests and interventions. No one reassures her that her body, her heart, are growing her baby or that she knows on a deep, intuitive level how to give birth. And no one lets her know that the choices she makes, hoping to insure the safety of her baby, are based on false assumptions and misinformation. In the pit of fear, only one choice is evident: hospital, doctor, interventions. But for the woman who can let go of her fear, maintain her confidence, and remain assured with the knowledge that safety does not depend on routine medical birth but on the wise and appropriate use of intervention when medically indicated, the world of choices begins to open up.

How can we help women move past fear and remain confident in their own ability? Childbirth educators can help women untangle the web of modern obstetrics and begin to understand that, too often, the very things that are meant to protect the safety of mother and baby do quite the opposite. However, this merely skims the surface of what needs to happen. Women need to reclaim birth. They need to delight in the incredible miracle to which they are central. Additionally, they need to surround themselves with friends and family who remind them over and over how strong and capable they are, not alert them to all the things that could go wrong. Each woman in your childbirth class deserves to feel the deep confidence that only comes when she knows she and her baby are on the journey together and the trip is theirs alone.

Some women come to our classes already confident, having made choices that will help them remain confident and joyful, even if they genuinely require medical interventions. But most women come to class having made choices that will feed the bottomless pit of their fear, no matter how hard we work to paint a different picture. What can be done late in the already "spoiled"

pregnancy to help women move beyond the fear, even a little bit? I am not sure, but I do not think practicing breathing, memorizing anatomy, and discussing the risks and benefits of alternatives accomplishes the task. It is decidedly not by withholding evidence-based information or by implying that routine hospital interventions are not a big deal and are valuable "just in case." Fear is contagious; therefore, the first step is to move beyond fear ourselves. I think much more time needs to be spent in class being "in the moment"; that is, addressing women's immediate fears and concerns; doing birth affirmations; showing normal, natural births; and sharing confidence-building birth stories. The six care practices that promote, protect, and support normal birth provide a framework for enhancing women's understanding of normal birth, in addition to increasing their understanding of what helps and hinders normal birth (Lothian, 2002a, 2002b).

Encouraging and convincing women of the value of normal birth, as well as the safety of normal birth for them and their babies, will create dissonance. The issues and choices women face can be overwhelming; keeping the fear can be so much easier than facing the possibility of change. I like to think of holding women's hands and softly encouraging them as they tentatively begin to think differently. Hand-holding involves repeating the simple story of birth and reassuring women that they know how to give birth. It includes debunking myths about the safety of medical birth and, at the same time, helping women understand the indications for medical intervention as well as the availability of medical interventions, even if birth takes place outside the hospital. I want women to *want* to give birth normally. But wanting normal birth is only the first step. Having a normal, not a medical, birth requires more than knowledge and confidence; it also requires strategy in the political world of birth. Letting labor start on its own requires desire, confidence, and a plan. We need to help women develop the plan for how that will happen for them. Sometimes, it means being willing to discuss changing health care

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providers or place of birth and, very often for the women we teach, it means hiring a doula.

We need to know a great deal more about women's fears, how they make their choices, and the ways in which we can help them gain confidence and give birth normally. In the meantime, we can neither ignore nor dismiss the deep safety-issue fears that women have. If we are to help women reclaim birth, we need to put women's fears on the table and face them head on—a formidable task for us as childbirth educators and as women.

References

- Centers for Disease Control. (2003). *Trends in cesarean birth and vaginal birth after previous cesarean*. Retrieved October 24, 2003, from <http://www.edc.gov/nchs/releases/03facts/cesarean.htm>
- Enkin, M., Keirse, M., Renfrew, M., & Neilson, J. (2000). *A guide to effective care in pregnancy and childbirth* (3rd ed.). New York: Oxford University Press.
- Kitzinger, S. (2000). *Reclaiming birth*. New York: Pocket Books.
- Lothian, J. (2002a). Questions from our readers: Commentary on "Lamaze in the 21st century." *Journal of Perinatal Education*, 11(1), viii–xi.
- Lothian, J. (2002b). Questions from our readers: Promoting, protecting, and supporting normal birth. *Journal of Perinatal Education*, 11(3), viii–x.
- Lothian, J., & Grauer, A. (2003). Questions from our readers—"Reality" birth: Marketing fear to childbearing women. *Journal of Perinatal Education*, 12(2), vi–viii.
- Rooks, J. (1997). *Midwifery and childbirth in America*. Philadelphia: Temple University Press.
- Rothman, B. (2001). Spoiling the pregnancy: Prenatal diagnosis in the Netherlands. In R. DeVries, C. Benoit, E. R. van Teijlingen, & S. Wrede (Eds.), *Birth by design: Pregnancy, maternity care, and midwifery in North America and Europe* (pp. 180–198). London: Routledge.
- Strong, T. (2002). *Expecting trouble: The myth of prenatal care in America*. New York: New York University Press.
- Wagner, M. (1994). *Pursuing the birth machine: The search for appropriate birth technology*. Camperdown, Australia: ACE Graphics.