# *Medicalization of childbirth and birth rate decline*[*]

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***Summary***. *According to the demographist Volpi (2007), the Italian family is undergoing a profound crisis, and it's statistically approaching what seems to be an announced end. Among the current changes in the "traditional" concept of family, he examined the causes of a clear decline in birth rates, mostly due to a "medicalization of pregnancy and childbirth". With reference to a previous work by Ravazzolo and Tessarolo (2009), this study intends to verify weather there is an actual relationship between medicalization and feelings of heartlessness in mothers. We administered a questionnaire to 168 young Italian mothers. Results confirmed findings from previous research by the same authors and in an opposite direction from Volpi's showing that medicalization offer greater serenity to new mothers.*

***Keywords:*** *motherhood, pregnancy, medicalization, birth rate decline*

Parenting is a socially shared expectation as becoming a parent is the crowning of a couple's union, the answer to a generational mandate which allows the continuity of society and family (Rossi, 2001). Parenthood is, therefore, a much idealized role expectation; parenting, on the other hand, is the actualization of a role that personally and practically involves the individual and the couple and find space in already "occupied" models that can change and tend to the satisfaction of personal needs. Waiting to become effective parents, we see a continued postponing of parenthood itself. Looking "historically" at the last forty years, we realized that the attitudes towards family has changed, and consequently, has changed family itself.

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We can identify, in fact, two really different critical periods. The first, around the 70's, started the death of family seen as the crib of repression, to the extent that only without family could a society be considered free. Among its theorists we remember Cooper (1971) and Laing (1969) who saw in the death of family a return to a primordial freedom (in accordance with Rousseau, although not purposely).

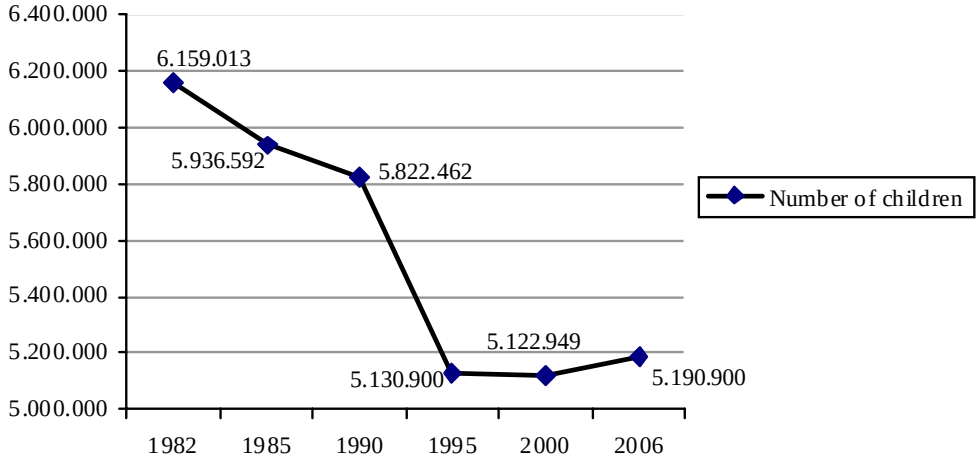
The second, between the XXI siècle, attributed the death of family to the fact that couples were no longer generating because of a strong individualization and a desire to have no responsibilities or bonds, deriving from giving birth and growing children, in a society that privileges "liquidity" (Bauman, 2006). What forty years ago was principally considered sexual freedom now is defined as a freedom from duties, a quest for an individual "happiness".

Morano (2010) notices that in the last decades the rhetoric of "motherhood mystic" has been abandoned and the attention has shifted from the fight to control fertility to the cure of infertility and the consequent ethical and political problems. The recent year's situation has led the demographer Volpi (2007) to theorize the end of family as a consequence to a decrease in birth rates in fertile couples, due to the choice of not having children, the fear of individual renounces and the medicalization of pregnancy and childbirth. This it's maternity that actually discourages another maternity.

**Medicalization of pregnancy and birth rates decline**

The transition from a "traditional" family to a variety of family typologies opens the discussion on the legitimacy of these changes. Today's family does not tend to procreation as it is perceived as disentangled from the duty of transmitting life and, thus, of transmitting lineage (progeny). In the last ten years, many studies have investigated such phenomenon and have identified the moment when the family transition to "other" models has taken place (Avanzino, Mazzocchi, & Scabini, 1984; Micheli, 1995; De Sandre, Ongaro, Rettaroli, & Salvini, 1997; Barbagli, Castiglioni, & Dalla Zanna, 2004; Gagné, & Petitpas, 2004; Cusinato & Panzeri, 2005). The number of women with no children, that is, childfree (Istat, 2003; 2004), born around the year 1960 is 14-15%, while those who didn't want children are about half of this percentage. "It needs to be taken into account, though, that 7% of women would like to have children but don't believe they would be able to for infertility or health reasons. On the other hand it is likely that the number of childfree women born around the year 1980 (that is with no children by the age of 45-50), will be significantly higher than this (Rosina & Testa, 2007, p. 77). A large proportion of couples have no children and among those who have them, the only child model is the most diffused:

today's family, as anticipated, is characterized by the tendency of a non essential reproduction. Recent statistics on birth rates, marriages and separations/divorces in Italy (Istat, 2005, 2006, 2007) show a worrying status quo worth reflection and intervention in our country, as a society with no children will be forced to fold back, stagnate and have no perspective for the future (Donati, 1998; Rossi, 2001; Cavanna & Migliorini, 2007; Meggiolaro & Onagro, 2007; Rosina & Testa, 2007; Tanturri & Mencarini, 2007; Tessarolo, 2007). The actual European tendency toward a decline in birth rates and the diffuse presence of an only child is presented in Figure1.




Source: Eurostat data (European report on the Family, 2007)

***Figure 1.*** Registered births in Europe from 1982 to 2006

Even geographically data on birth rates are almost constant (Table 1) with higher percentage in the Nord.

***Table 1.*** Couples with children and number of children per geographic area (Means, year 2005-2006, from the National Observatories on the Family web site)

| Geographic zones in Italy | Number of children | | | |
|---|---|---|---|---|
| | one | two | three or more | total |
| Nord-west | 54.1 | 38.2 | 7.7 | 100 |
| Nord-est | 50.5 | 40.7 | 8.8 | 100 |
| Centre | 48.5 | 43.7 | 7.8 | 100 |
| Sud | 36.8 | 45.9 | 12.7 | 100 |
| Islandes | 37.9 | 47.0 | 15.1 | 100 |

In few decades, the family has dramatically changed and could modify itself more as the process triggered could be irreversible or represent a temporary transition. If this tendency should continue it could result in further population aging and, in a society that remains a close system, and in a decline of the population itself: decline and closure, thus, could influence cultural, social and economical processes. On the other hand, birth rate declines, per se, is not a fatal risk for western societies, neither it is appropriate to simply attribute it to a fundamental selfishness assumed to be characteristic of today's social fabric. However, it needs to be attended to as a sign of a more profound discomfort that, from the collective imaginary with no linear paths, has repercussions on behaviors. The choice not to have children is to be attributed, according to Volpi (2007) to a medicalization of pregnancy, that is, the "power exerted by medicine on the entire process from conception to birth".

It seems that couples and mothers are adhering to the dictates of a highly specialized and organized society, already meeting maternity needs at pregnancy. The idea that what is done is never enough for the child, is strictly determined by this medicalization phenomenon, that confines mothers-to-be to a relational system where what is really important is the opinion of a physician or the result of a test. In this psychological condition, mothers tends thus to exceed in medical assistance not to be blamed or to regret not having done all possible at the right moment. This way pregnancy could be experienced by a woman as a power condition of psychological determination rather than of uncertainty and doubts on her actual abilities with a multiplicity of medical procedures not increasing her security and serenity but rather making her more fragile, exposed and unsure about the past. Clearly a new born brings changes in every aspect of life and requires parents to make renounces and sacrifices that push them to prefer a life of alternative opportunities, satisfactions and goals over children. Once the principal goal of a union between two partners was having a child, while now the couple is moving toward a new, unknown, more rewarding and innovative direction, a full life quite different from parenting that become their priority. However, from recent studies it has emerged that the desire for a child is still present, as evident in a comparative study in France and Italy, which are in opposition as for reproductive behaviors, showing that the number of children desired by French mothers is only a little higher that Italians and that the profile of women moving away from the desire for at least two children is similar for the two countries. This research shows that there still exist a desire for maternity and a numerous family, what is lacking though are the necessary social incentives to make it happen (Vignoli & Régnier-Loilier, 2009). A survey by Istat (Italian Statistics Institute) on "Pregnancy, birth and breast feeding" (2004-2005) on a sample of 2.736.000 showed a rise in medicalization of childbirth and an overuse of diagnostic tools compared to the years 1999-2000. There have been, however, previous

studies (Wagner, 1998; Spano & Facco, 2001; Livi Bacci & Breschi, 2003) to refer too. Results showed that, while the national protocol recommend a maximum of three sonograms for a physiological pregnancy, 78.8% of interviewed women had performed at least three sonograms with an increase compared to 1999-2000 data which were already high (75.3%). The number of women with 7 or more sonograms done also increases (from 23.8% in 1999-2000 to 29.0% in 2004-2005) especially in then South and Islands (respectively 32.4% and 34.4%) (Table 2).

***Table 2.*** **N**umber of sonograms and physician visits during pregnancy (Istat data 2004/05; per 100 women with same characteristics)

| | Women who underwent more than three ultrasound | women who underwent seven or more ultrasounds | women who had seven or more examinations |
|---|---|---|---|
| **job** | | | |
| Family physician | 74.3 | 22.1 | 45.9 |
| Private gynecologist who works in a private hospital | 81.7 | 35.8 | 60.1 |
| Private gynecologist who works also in a public hospital | 81.0 | 30.6 | 58.2 |
| Public gynecologist | 68.8 | 12.3 | 46.8 |
| Obstetrician | 63.0 | 15.8 | 33.8 |
| **geographical area** | | | |
| northwest | 76.6 | 25.7 | 59.1 |
| northeast | 79.7 | 24.4 | 58.4 |
| center | 81.7 | 27.0 | 65.0 |
| islands | 79.1 | 32.4 | 47.2 |
| south | 81.6 | 34.4 | 55.2 |
| **serious problems during pregnancy (a)** | | | |
| No | 73.9 | 26.1 | 52.1 |
| Yes | 84.7 | 38.9 | 71.0 |

(a) we consider a serious disorder in pregnancy a threatened preterm labor, threatened abortion, diabetes, hypertension, gestosis

The percentage of women with 7 or more physician visits rose from 52.7% in 1999-2000 to 56.5%.

More often these women see a gynecologist (60.1%) with his/her own practice or also working at the hospital (58.2%). The mean number of physician visits during pregnancy was 7, higher for women with a higher degree (college or diploma, 7.4 and 7.1 respectively) and lower for women with a primary school diploma or none (6.2). It emerges that the difference between what is nationally recommended and the actual data mean collected is accounted for only in part by a small percentage of pregnancies at risk (22.7%) but mostly by pregnancies with no complications, which are

interested in the medicalization phenomenon. In fact, women who experienced serious problems during pregnancy showed an average level of sonograms (6.2) not so different from the cumulative mean average (5.5) and similarly an average level of physician visits, little above the mean (8 over 7). The practice of C-section (caesarean section) is also increasing: Italy is the European country with the highest number. The survey results showed that at the beginning of the 80's about 11-12% of women needed a C-section, 29.9% in 1999-2000, 36.9% in 2003 up to 35.2% in 2004-2005, thus confirming a rise in medicalization above the criteria established by OSM (Worldwide Health Organization) in contract with data from USA, Canada and EU where the mean number of C-sections performed is 23.7%. The C-section quote, generally on the rise in all national territory, reaches particularly high values in the Southern part of Italy (from 34.8% to 45.4%) and the Islands (from 35.8% to 40.8%) while the Nord has the lowest values, 27.4%, both in the eastern and western parts. The rate of C-section for women with grown up children as well as women younger than 25 year old, is around 32.9%, still a much higher percentage than recommend by OSM. Despite the existing strong association between complications during pregnancy and C-sections (43.3%), especially with women in gestosis (59.1%) and with hypertension (56.8%), and considering the low incidence of these pathologies, the number of C-section is still high and indicates an excessive medicalization. It needs to be highlighted that the higher incidence of sonograms and C-sections is found in women with a private gynecologist (about 81%) and giving birth (delivering) in private clinics (56.9%), registering 23 percentage points more than women in public hospitals (33.3%).

Childbirth (Lamaze) classes are one of the protective factors against the request for a C-section, as women participating are already a selected group characterized by a tendency to de-medicalization, and plus this type of training increases women's ability to make their own decision about giving birth, as only 27.6% of women who enrolled in this training groups had a C-section their last or previous pregnancy, compared to 41.5% of those who didn't enroll. Among women that had a C-section in the past 5 years, 62.6% had it planned compared to a 37.4% who didn't. In the South (72.6%), women with a private gynecologist (65.3%) or giving birth (82.8%) in a private hospital are those with the highest percentage of planned C-sections. As expected, the number of planned C-sections is higher for older mothers and those at risk, but these factors alone do not explain the frequency of assisted births. 35.8% of women with more than one child had a C-section and 94.2% of those repeated the same choice for the next pregnancy. Women prefer to give birth naturally (87.7%). Among those who experienced a natural delivery with or without epidural, only 5% would have chosen to have a C-section instead. Does not make sense! 75% that clearly had a C-section are getting what they wanted (Table3).

**Table 3.** Women who gave birth with a c-section in the previous 5 years (Istat data 2004-2005- per 100 women with same characteristics)

| | Caesarean | planned caesarean (b) | unplanned cesarean (b) |
|---|---|---|---|
| **age of childbirth** | | | |
| up to 24 years | 32.9 | 50.3 | 49.7 |
| 25-29 | 32.8 | 56.3 | 43.7 |
| 30-34 | 33.6 | 65.1 | 34.9 |
| 35-39 | 38.7 | 68.1 | 31.9 |
| Over 40 | 52.5 | 69.0 | 31.0 |
| **facility** | | | |
| public facility | 33.3 | 60.5 | 39.5 |
| accredited private facility | 47.1 | 69.8 | 30.2 |
| private facility | 56.9 | 82.8 | 17.3 |
| **disorders during pregnancy (a)** | | | |
| Yes | 43.3 | 58.8 | 41.2 |
| no | 32.8 | 64.1 | 35.9 |
| **during childbirth** | | | |
| yes | 27.6 | 51.4 | 48.6 |
| no | 41.5 | 68.8 | 31.2 |

(a) we consider the participation to birthing classes for the latest or a previous pregnancy
(b) on 100 women with cesarean section

## The research

We built our research on Volpi's statement that motherhood discourage motherhood and our hypothesis aims to verify if actually the decline in desire for children is attributable to the "disproportionate attention to pregnancy and the pain of giving birth" (Morano, 2010, p. 5). Specifically the present research intent to:

- highlight the concerns that greatly accompany the period of pregnancy;
- investigate whether on average motherhood represents a positive or negative experience and whether in general it is experienced without constrains;
- verify whether medical procedures are sources of anxiety and lead to a less spontaneous and serene motherhood experience;
- determine if substantial geographical (South-North of Italy) differences exist.

### Procedure

We administered a revised version of the Ravazzolo and Tessarolo's (2009) survey on the same themes adding 8 items, introduced by a general question on pregnancy: "Was your pregnancy a serene experience?", followed by more specific questions in the area of interest such as: "The

experience of the first pregnancy, per se, apart from the joy of having a child, has tempted you to consider a second pregnancy in the future?" or "… the choice not to consider a second pregnancy now, or in the future, is determined by …".

The choice of this survey's structure derives from the willingness to gradually accompany the subjects to the research questions, and then specifically stimulate their reflection on some issues. Answers were given on a 5-point Likert scale (1 absolutely agree to 5 absolutely disagree). In a few initial questions, we preferred dichotomous items.

### The sample

The sample (No 168), characterized by women having experienced a pregnancy in the last 10 years, was collected partially in Sicily (n = 60) and the remaining in the Veneto region, mostly in the Padova and Vicenza province. Local daycares agreed on delivering the survey to mothers, who then passed it over to other mothers, through word of mouth. We used a "non-probabilistic snow-ball sampling" (De Carlo, & Robusto, 1996).

51.5% of respondents are younger than 35 years old, the remaining 48.5%% above or equal. As for their educational level, 22.2% have a primary/middle school diploma, 56.9% a high school diploma, and the remaining 21% a college degree. 44.9% have only one child, 53.9% have two/three children and only a small percentage, 1.2% had more than three. 1.7% of women below the age of 35 are from the South, while 64.2% of women 35 years old or above are from the North .

## The research questions

We grouped all survey items based on the following area of investigation: *Serenity:* it includes questions on the experience of pregnancy. A high score indicated a high agreement on motherhood being a positive experience. The items were:

Pregnancy has been a positive experience;

I remember my pregnancy as a happy time;

I have experienced my pregnancy and the idea of giving birth with anxiety;

I have experienced my pregnancy and the idea of giving birth with serenity.

*Medical assistance:* it includes question on the weight medical assistance had during pregnancy. A high score indicates a high agreement on motherhood requiring heavy medical assistance. The items were:

Physician visits during my pregnancy were too numerous;

Medical assistance increases the normal degree of anxiety on the positive outcomes of pregnancy;

I would have preferred less physician visits during my pregnancy to live those 9 months with a greater serenity;

I was afraid of the medical assistance process.

*Spontaneity*: it includes only the question:

I have experienced my pregnancy as something natural and spontaneous.

**Statistical analysis**

We first run some preliminary analysis on the frequencies of factors "serenity" and "medical assistance". For each factor we calculated a Cronbach alpha and the correlation with the dependent variables: geographic area of origin, age, education and number of children. Both factors yield a good internal consistency, with a Cronbach alpha of 0.76 for "serenity" and 0.68 for "medical assistance". Figure 2 shows the distribution of scores between the interval value of 4 and 5, that is toward absolute agreement for a serene pregnancy (mean=3.99, median=4.2, SD= 0.822).

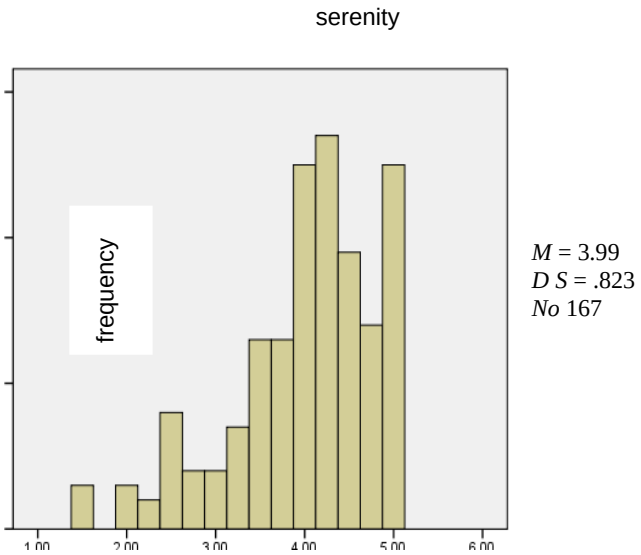



***Figure 2.*** Scores distribution for factor "serenity

Figure 3 shows, on the contrary, that for "medical assistance" the scores distribution were mostly around values 1 and 3, that is on low values of agreement (mean= 2.30, median=2.25, SD=0.87).

Both factors' means confirm a medium-high agreement with the idea of pregnancy as a serene period and a low agreement on the idea that a

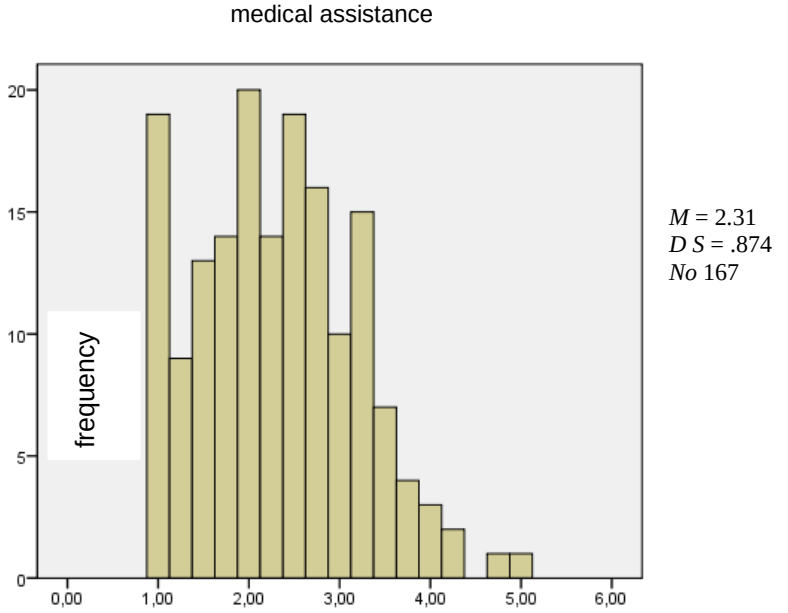



***Figure 3.*** Scores distribution for factor "medical assistance"

programmed medical assistance causes anxiety and difficulties during pregnancy.

## Pregnancy experience and the lack of desire for a second child

The first item of the survey pertains to the question weather pregnancy was a serene experience: 85.6% of mothers declared to have experienced their pregnancy serenely, without particular problems, while only 14.4% stated otherwise. Results for this first item are in line with all others and show a general idea of pregnancy as a positive experience. The second and third questions aimed to explicitly confirm our hypothesis that "motherhood discourages motherhood", thus investigating the motivations not to have another child by those mothers who lacked the desire for a second pregnancy: 13.8% of our sample. The most frequently reported motivation coincides with the idea that a difficult pregnancy discouraged a further desire for a child, which is an understandable and objective reason. However, the influence of a programmed medical assistance does not seem to influence much the decision not to have another child. These results anticipate our conclusion that, in general, there is a low agreement on the fact that pregnancy, and the need for a programmed medical assistance, is perceived so heavily to negatively influence further reproductive choices. The positivity of the experience of pregnancy is evident from data showed in Table 4.

***Table 4***. Characteristics of Pregnancy as Experienced

| Questions | *M* | *DS* |
|---|---|---|
| "Pregnancy was a positive moment" | 4.48 | 0.798 |
| "I remember pregnancy as a happy period" | 4.37 | 0.959 |
| "The months of pregnancy were full of concerns, hoping all was going well" | 3.51 | 1.156 |
| "I underwent too many medical examinations during pregnancy" | 2.63 | 1.332 |
| "The MEDICAL CARE during the months of pregnancy lessened my concerns " | 3.90 | 0.964 |
| "The MEDICAL CARE one has to undergo increases the normal degree of anxiety" | 2.54 | 1.298 |
| "I would have preferred the pregnancy required less medical examinations so the nine months could have lived with greater tranquility" | 1.97 | 1.194 |
| "I lived pregnancy as something natural and spontaneous" | 4.39 | 0.917 |
| "I lived with pregnancy and motherhood as something to learn" | 4.07 | 1.059 |
| " I lived pregnancy and the idea of childbirth with anxiety" | 2.59 | 1.231 |
| "I lived pregnancy and the idea of childbirth with tranquility" | 3.72 | 1.269 |

Results showed that mothers' degree of agreement on the statement presented clustered around high mean values, indicating that pregnancy, for the majority, has been an happy time, generally experienced with serenity.

## Concerns during pregnancy (or motherhood concerns)

This theme is in line with the principal aim of our research. For this reason we collected information on the elements that can be the source of worries and tension during pregnancy.

***Table 5***. Concerns during Pregnancy

| Questions | *M* | *DS* |
|---|---|---|
| "Fear of physical pain" | 2.85 | 1.483 |
| "Fear for the health of the baby" | 4.11 | 1.183 |
| "The fear of not being up to the new role of parent" | 2.62 | 1.296 |
| Fear of the new responsibilities" | 2.70 | 1.310 |
| "Fear in undergoing the planned MEDICAL CARE" | 2.08 | 1.072 |
| "Fear of changing habits' | 2.38 | 1.251 |

Results indicate that “Concern for the health of the newborn” is the most frequent, as 76% of mothers assigned to this item the highest values showing a really high agreement. We want to highlight, once again, that the item investigating the influence of programmed medical assistance “Concern for medical procedures” yielded the lowest mean value (2.08) as 64.4% of women interviewed has chosen this item as the lowest interval of the Likert scale, indicating a disagreement, partial or absolute, with the statement. The items “Concern not to be up to the parenting role” and “Concern for new responsibilities”, as shown in Table 5, didn’t yield relevant results. We cannot exclude, however, that motherhood is, from different point of view, a revolutionary experience in the life of a woman, and although the concern for the health of the newborn seems the principal source of worries, we cannot underestimate the influence of psychological dimension related to parenting and its responsibility. We further analyzed the data using parametric and non parametric statistics to investigate potential significant correlation between variables of interest.

## The desire for motherhood

The initial question pertains to the desire for another child. We analyzed the response to this question in relation with the independent variables, that is age, education, number of children, and origin and calculated Pearson’s chi square and exact Fisher test when necessary. We found a significant relationship with number of children: those who reported having only one child are also those (82.6%) who responded “No” to the question “Did your first pregnancy experience tempt you to have a second child in the future?” Results in Table 6 confirm women’s tendency to adhere to the only child model being satisfied with their family condition and having no intention or desire to modify it.

From the interaction between the item “Do you want another child?” and geographic origin, it emerged that more women from the North than from the South are interested in another pregnancy (87.9% versus 83.3%).

***Table 6.*** Relation between Number of Children and Desire for another Pregnancy

| | | | Do you want another pregnancy? | |
|---|---|---|---|---|
| | | | yes | no |
| **Number of children** | **1 child** | **%** within question 2 | 38.9% | ***82.6%*** |
| | **2 children** | **%** within question 2 | 60.4% | 13% |
| | **3 or more chidren** | **%** within question 2 | .7% | 4.3% |
| | **Value** | **Df** | ***p*** | |
| **$K^2$** | 18.91* | 2 | ***.002*** | |

From the interaction with the item “Did you experience your pregnancy in a calm way?”: 88.2% reported having spent their pregnancy quietly and be tempted to have another child, while for 30.4% of respondents it didn’t represent a stimulus fro another pregnancy (p=0.018). Among respondents who said they experienced a serene pregnancy, 28.6% reported not to want another child. Even in this case, there is a positive correlation between the serene pregnancy item and geographic origin, as quantitatively more women from the North stated their pregnancy was calm (89.7% versus 78.3%; $p$ = .039).

Similar results have also been found between geographic origin and one of the research area investigated. Table 7 shows the difference between the two groups with reference to the variables of factor “serenity” and in particular that more women from the North reported experiencing pregnancy with serenity and without difficulties than women from the South.

***Table 7.*** Relation between geographical origin and pregnancy experience

| | **Place of origin** | ***M*** | ***SD*** |
|---|---|---|---|
| **Medical Assistance** | nord | 2.32 | .857 |
| | south | 2.28 | .910 |
| **Serenity** | nord | ***4.10*** | .818 |
| | south | ***3.80*** | .802 |
| **Spontaneità** | nord | 4.36 | .905 |
| | south | 4.43 | .945 |

$t$ = 2.29 (165) , $p$ < .05).

Finally, we formulated unidirectional hypothesis between variables of interest and we run some non parametric correlations. Table 8 reports a positive correlation between serenity and spontaneity, showing that as the serenity level increases the pregnancy is more spontaneous. On the other hand, there is a negative correlation between medicalization and spontaneity indicating that an excessive medicalization decreases the degree of spontaneity a woman experience during pregnancy.

***Table 8.*** Non Parametric correlations between variables

| | | | MEDICAL ITER | TRANQUILITY | SPONTANEOUSNESS |
|---|---|---|---|---|---|
| Spearman's rho | MEDICAL CARE | *r* | 1 | -.152 | **-.203**** |
| | TRANQUILITY | *r* | -.152 | 1 | **.434**** |
| | SPONTANEITY | *r* | -.203** | .434** | 1 |

** The correlation is significant at level 0.01

## Conclusions

Results do not confirm the initial hypothesis: it is not the programmed medical assistance that discourages the desire for a second child, as

previously found by Ravazzolo and Tessarolo (2009). Pregnancy and delivery medicalization condition women's way to think about what is appropriate and what is not, about what is necessary in terms of prenatal technologies. A check on the pregnancy progression, in reality, guarantees greater serenity to mothers. Probably, a programmed medical assistance, although demanding, is not enough in discouraging the desire for another child, and perhaps what plays a fundamental role is not connected to the pregnancy experience itself but on external factors (for instance, economic issues).

Results highlighted interesting issues worth to be considered for further analysis and discussion. For example, we could hypothesize that Volpi's point of view on the medicalization process is actually a male perspective, in contrast with what a woman directly experiences. What could be seen as a mandatory and difficult path made of physical checks and doctor visit is indeed interpreted differently by women and men: if for the former it could represent a form of personal reassurance, for the latter the same situation could be interpreted as a type of violence and thus as a source of tension, anxiety and discouragement. It would be, then, appropriate to evaluate as medical assistance in general, is perceived based on gender, comparing a male (with reference to their female partners) and a female sample on the medicalization issue.

Moreover, it need to be considered that our research was carried out considering pregnancy in general terms, without investigating in details the importance of specific health concerns or risks and their consequences on the pregnancy. Further research on this issue with a sample of women having experienced different pregnancies, at risk or not, has to be considered.

Parenting inherent difficulties are not in doubt because the space a child takes is never be interstitial, but real and makes the couple's thinner so that they have to rebuild their own considering the child. Literature on parents and children highlights difficulties and crises that arise within the couple because of children and their education (Tessarolo, 2006). Probably the lack of desire for a child needs to be accounted for by what happens after the child birth, by the "nothing" as it is defined by Morano (2010, p. 3) that continues: "paradoxically today more than yesterday a woman who gives birth to a child is socially accompanied by her only choice". When after delivery, a woman takes home her child she find herself alone, as the interest for her and her child decreases, and social policies are not so present as during pregnancy. Motherhood is a primary social value in any society and does not correspond with the pregnancy period, but with a different intensity and different needs that it lasts a life time.

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