



TOKOPHOBIA – IMPACTS ON SERVICE AND WOMEN'S CHOICES

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WORKSHOP OVERVIEW AND AIMS

What is birth fear?

Primary and secondary tokophobia

What this means for women

How do we screen and recognise tokophobia?

How can we support women in pregnancy to achieve a positive birth?

Interventions for tokophobia

The midwife's and obstetrician's role

Caesarean section for non-medical reasons

Psychologically informed birth planning

WHAT IS TOKOPHOBIA?

Fear is a distinct emotion from anxiety

Fear of childbirth (FOC) is common,
tokophobia is rarer

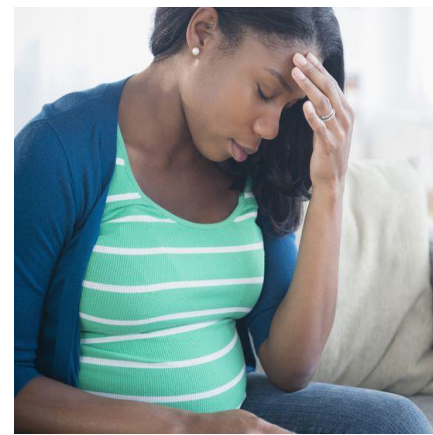
Fearful predictions vs. fearful
memories

Can be primary or secondary

Term tokophobia first introduced in
2000 (Hofberg & Brockington)



WHAT IS TOKOPHOBIA?



Not included in DSM-5 or ICD-10

Can be a very specific fear or include comorbidities

Includes a wide variety of fears and presentations relating to childbirth

Close relationship between childbirth and mental state/anxiety

“A woman with tokophobia is likely to experience severe anxiety symptoms during pregnancy that will impact on her birth experience and the care that she requires”.

Hofberg K, Brockington IF. Tokophobia: an unreasoning dread of childbirth: A series of 26 cases. The British Journal of Psychiatry 2000, 176 (1) 83-85

WHY ARE WOMEN FEARFUL?

Construct of birth fear - 10 key elements:

Fear of not knowing and not being able to plan for the unpredictable

Fear of harm or stress to the baby

Fear of inability to cope with the pain

Fear of harm to self in labour and postnatally

Fear of being 'done to'

Fear of not having a voice in decision making

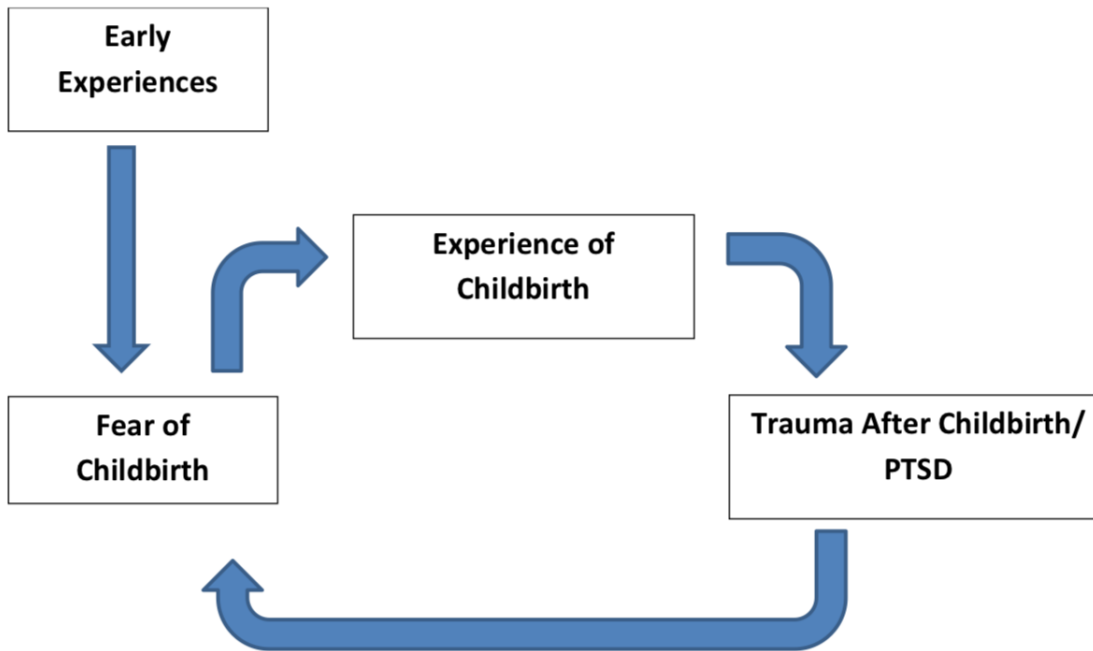
Fear of being abandoned and alone

Fear about my body's ability to give birth

Fear of internal loss of control

Terrified of birth and not knowing why

FEAR OF CHILDBIRTH AND THE RELATIONSHIP BETWEEN PRIMARY AND SECONDARY TOKOPHOBIA



When did the fear start? Early in life (primary) or after childbirth (secondary)?

Childbirth experience can trigger or compound fear of childbirth

Secondary tokophobia as PTSD after childbirth

KEY POINTS ABOUT PRIMARY TOKOPHOBIA

Worldwide prevalence approx. 14% (O'Connell 2017)

- Depends how it is measured.

It can be difficult for women to express their fear, can have intense **feelings of shame and guilt**

There is not always a specific trigger or cause, some women will display **phobic behaviours**

Through **stories** of fear of childbirth (learned association)

KEY POINTS ABOUT PRIMARY TOKOPHOBIA

A recent meta-synthesis identified the content and moderators of FOC. Overarching theme: ***'the unpredictability of childbirth'*** (Sheen et al, 2018)

Moderators of fear: birth experience, general information about birth, support from care providers.

Women with FOC are more likely to be **intolerant of uncertainty** and interpret an **ambiguous situation as negative**, therefore have **increased need for information**

Can have significant impact on **whole family**, and **increased risk of PND or PTSD**

KEY POINTS ABOUT SECONDARY TOKOPHOBIA — BIRTH TRAUMA / PTSD



Subsequent to a previous traumatic delivery or miscarriage /stillbirth — perceived trauma ‘in the eye of the beholder’

Key symptoms:

- **Re-experiencing:** Frequent thoughts or images of the birth, nightmares, flashbacks, high levels of distress or anxiety
- **Avoidance:** Avoiding reminders of childbirth (e.g. hospitals, TV programmes about birth, friends who are pregnant, avoiding talking about or thinking about childbirth)

KEY POINTS ABOUT **SECONDARY** TOKOPHOBIA — BIRTH TRAUMA / PTSD



- **Hyperarousal:** sleep problems, hypervigilance, exaggerated startle response,
- Some women report **emotional numbing**
- Can lead women to only have one child, or a large gap between pregnancies
- Often choose to deliver at a different hospital

THERE ARE SEVERAL RISK FACTORS FOR BIRTH FEAR:

- Previous childbirth that was experienced as traumatic
- Previous adverse medical / surgical experience
- Previous traumatic experience of witnessing childbirth
- Pre-existing anxiety or mood disorder
- History of sexual abuse or rape
- History of sexual dysfunction
- Previous miscarriage, stillbirth or neonatal death

SOME OF THE FACTORS THAT MAKE BIRTH TRAUMA MORE LIKELY ARE:



CLINICAL PRESENTATION

Intense fear of childbirth with **high levels of anxiety**, commonly escalate as pregnancy progresses

Commonly **request a Caesarean** section for non-medical reasons (sometimes anxiety about Caesarean also)

May have **delayed or avoided pregnancy** in spite of wanting a child

May have had **previous termination of pregnancy** due to FOC (including assisted conception)

May **avoid discussing pregnancy**, telling others, conceal bump.

CLINICAL PRESENTATION

Sometimes only disclose anxiety late in pregnancy (**avoidance**)

May express **revulsion** at pregnancy and/or birth

Can carry **risk of harm to self or baby** (may escalate after 24 weeks)

May have become fearful through stories of fear of childbirth (**learned association**)

May have **psycho-sexual difficulties**

IMPACT OF TOKOPHOBIA

Some studies found **association with increased probability of emergency or elective Caesarean section** (Waldenstrom, 2008, Raisenen et al., 2014) but not found to adversely affect other pregnancy outcomes

Maternal anxiety and/or PTSD during pregnancy has **long term consequences for the infant** (O'Connor et al., 2005; Yehuda, 2005)

Affects the mother's feelings towards the baby during pregnancy and postnatally, **impacting on developing attachment** with potential long-term consequences (Reid, 2011)

SUPPORTING WOMEN WITH BIRTH FEAR: ROLE OF MATERNITY SERVICES

Really important to have psychological wellbeing assessment **embedded in routine antenatal care**

Early recognition via **universal screening and acknowledgement** is key – this requires mandatory training for all maternity staff and a trauma-informed approach

Prompt referral to PNMH midwife for assessment and +/- IAPT / PNMH specialist service

Intensive specialist midwifery support, continuity of care

Individualised birth planning

Timely referrals for **psychological treatment**


Referral to **obstetrician** due to request for MRCS (rational response to fear avoidance)

Interventions should be offered to **support mental wellbeing** regardless of planned mode of birth

LOCAL PATHWAYS - IMPROVING ACCESS AND PROMOTING THE BENEFIT OF PSYCHOLOGICAL THERAPIES

- Establish links with local **talking therapy** 'IAPT' services
- **Co-locate** PNMH services within maternity settings if possible
- Provide **clinic space** within maternity services e.g. twice weekly referral and assessment clinics run by Hounslow perinatal champion therapist in ANC - Hounslow consistently have the highest perinatal referral rate in London
- Promote **psychoeducation interventions** e.g. 'My Mind & Baby' stress and worry workshop run by IAPT
- **Wellbeing and mindfulness events** for women – yoga / hypnotherapy workshops

My Mind & Baby



Free antenatal workshops for expectant mums and dads, designed to support your and your baby's wellbeing during pregnancy and beyond.

Includes:

- Mindfulness for pregnancy, birth and postnatally
- Relaxation techniques
- Managing stress and worry
- Preparing for the "fourth trimester"
- Support available during pregnancy & beyond

Workshops are run once a month:

Wednesday 15th August or
Wednesday 12th September or
Wednesday 24th October or
Wednesday 14th November or
Wednesday 12th December

9:30-10:30am
Queen Mary Maternity Unit Antenatal Clinic

PART OF WIDER STRATEGY FOCUSING ON MENTAL HEALTH & WELLBEING IN PREGNANCY



Having your baby at West Middx?
Are you 28+ weeks pregnant?

We are running FREE

Pregnancy Yoga classes

Learn how to 'relax, stretch, and breathe' for your pregnancy and birth on a 4-week course with specialist pregnancy yoga teacher Sarah Bradley

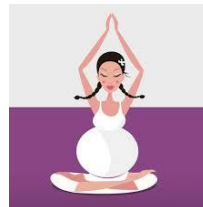
Tuesdays 10.00-11.30am
Starting August 8th

In Room B, Ground Floor, Queen Mary's Maternity Unit, West Middlesex Hospital

Places are limited!
To book your place please email:
Fiona.Teague@chelwest.nhs.uk



Perinatal Mental Health Partnership in Innovative Education
Mental Health & Wellbeing around pregnancy - support, educate, empower



'Dads To Be' Class

One-off FREE workshops to prepare for the birth and becoming a dad!

Topics include...

When we're home, how will we juggle time, sleep, new roles, energy, work, money, sex, and parents?

Now that there are 3 of us, how does that affect us?

When do I need to take her to hospital?

What is my role in the birth process?

What are the signs that my partner may have postnatal depression?

When?

Monday 21 May 2018
Monday 16 July 2018
Monday 24 September 2018
Monday 26 November 2018

Where?

The Conference Room, Education Centre Workshop, West Middlesex Hospital
Time: 6.30pm-8pm

BOOK NOW

Call 0208 321 5007 or visit the Antenatal Clinic desk

Workshops led by a Midwife Antenatal Educator and 'Dads to Be' facilitator.
For further information visit dadstobe.org



CULTIVATING WELLBEING DAY AT THE SALOPIAN KITCHEN GARDEN



PREGNANCY AND YOUR MENTAL HEALTH AND WELLBEING

Pregnancy and the period after childbirth are significant times of change in a woman's life. It is common for women and their partners to experience many different emotions during this time.

The attached Wellbeing Plan can help you start thinking about how you feel and what support you might need in your pregnancy and after the birth. We recommend that you complete this and you can share it with your partner, family, GP, obstetrician or midwife if you want to.

WE ARE HERE TO HELP

Please tell your midwife, GP or obstetrician if you have mental health problems or have had a mental illness in the past. They can ensure you get the care and support you need.

There is plenty of support in the local area including talking therapies and support groups as well as on-line resources.

Please ask your midwife, GP or obstetrician for more information.

Some women have mental health problems in pregnancy or after birth. These can either be illnesses that women have had before or for some women, it may be the first time they become unwell.

Depression and anxiety are the most common mental health problems in pregnancy and after the birth of a baby.

Your mental health can be affected by many things during your pregnancy including:

- The type of mental illness you have experienced
- Whether you are having treatment
- Recent stressful events in your life
- How you feel about your pregnancy
- Your own experience of childhood and being parented
- The support available to you

SPECIALIST SUPPORT

Some women with previous mental illness have a high risk of becoming unwell after birth, even if they have been well for a long time and have no symptoms when they become pregnant. It is important that these women have specialist advice and care.

Your midwife, GP or obstetrician may refer you to the Specialist Perinatal Mental Health Team. This team includes a psychiatrist, psychologists and specialist nurses. They offer assessment, treatment, advice and support for women who have current or previous moderate to severe mental illness. The team works alongside specialist obstetricians and midwives.

Mental health problems are more common than physical health problems in pregnancy, affecting up to 20% of all women.



Chiswick and Westmead Hospital

West London Mental Health

PREGNANCY AND YOUR MENTAL HEALTH AND WELLBEING

RESOURCES YOU MAY FIND HELPFUL



Information and support on many aspects of pregnancy and parenting with information about local resources. Support for depression and anxiety – <https://www.netmums.com/support>

Ealing IAPT
Hounslow IAPT

Richmond Wellbeing Service
Talking Therapies and Specialist Support
www.richmondwellbeingsservice.nhs.uk

IAPT – Improving Access to Psychological Therapies is the NHS Talking Therapies service.

All local teams offer a range of talking therapies to women and partners who are experiencing difficulties with low mood or anxiety. You can self-refer, or your GP, obstetrician or midwife can refer you.



Royal College of Psychiatrists Health Advice
www.rcpsych.ac.uk/healthadvice/problemsdisorders.aspx or via the RCPSych Mental Health App
Leaflets available for download include –
Planning a Pregnancy
Mental Health in Pregnancy
Postnatal Depression
Postpartum Psychosis
Perinatal OCD

My Mind & Baby workshop

Hounslow IAPT hosts a monthly 1 hour workshop for parents-to-be at any stage of pregnancy, with the aim of supporting your wellbeing by focusing on:
Mindfulness for pregnancy and birth
Relaxation techniques
Managing stress and worry
Preparing for the 'fourth trimester'
Support available locally
Classes are held within the West Middlesex Maternity Unit – to book a place call Hounslow IAPT on 0300 123 0739 (NB: this workshop is open to any mother booked for maternity care at West Middlesex hospital)



Chiswick and Westmead Hospital

West London Mental Health

Tommy's

Tommy's has information about a range of mental health issues, support and treatment options.
<https://www.tommys.org/pregnancy-information/im-pregnant/mental-wellbeing>

Practising Mindfulness and self-meditation techniques help to reduce fears and anxiety. Try one of these apps.
Mind the Bump, Headspace, Mindfulness for Pregnancy



www.birthtraumassociation.org.uk
Information and support for women and partners who have experienced a traumatic birth experience.



Free app with information on all aspects of pregnancy, mental health and breastfeeding



My pregnancy & post-birth wellbeing plan

This plan is to help you prepare the support you might need to look after your mental health. While coping with the physical changes in pregnancy, birth and beyond, your emotional health is important too. Many women feel anxious, unhappy, mentally distressed, depressed or even more severely mentally unwell during this time, which can be unexpected.

This plan is to help you think about the support you might need to look after your mental health and wellbeing. It is your decision whether to share it with anyone else

How am I feeling?

Take a moment to write about how you feel now, your thoughts about the birth and how you feel about your baby.

You may have mixed emotions about your pregnancy and your baby. This is completely normal. Here are some common signs that you should talk through with your midwife or health visitor:

- Tearfulness
- Feeling overwhelmed
- Being irritable/arguing more often
- Lack of concentration
- Change in appetite
- Problems sleeping or extreme energy
- Racing thoughts
- Feeling more anxious
- Lack of interest in usual things

Some women can also have:

- Intrusive thoughts
- Suicidal thoughts
- Strict rituals and obsessions
- Lack of feelings for their baby

Talking about how you are feeling helps you get through the exciting yet challenging time of becoming a parent. It doesn't matter who you talk to, but it is worth having someone in mind that you can trust and who can support you if needed. One of the first steps to getting better is knowing and accepting that you are unwell.



Boots Family Trust

Often your friends and family will spot that things aren't quite right before you do.

I will ask and talk to them about things troubling me.

Also, ask yourself...

Am I the sort of person who accepts that I'm unwell?

How might I start the conversation if I feel embarrassed?

Who else can I turn to if I don't feel listened to or supported?

*You may want to share this wellbeing plan with them

Embedding wellbeing information as part of routine care

Help and emotional support during pregnancy and the first year after having a baby

Having a baby can be joyful, exciting and rewarding. However, it is also common for pregnant women and new mothers or fathers to experience anxiety, depression or emotional distress.

As many as one in five women experience emotional difficulties during pregnancy and in the first year after their baby's birth. This can happen to anyone.

Every London borough has an IAPT service which offers free, confidential talking therapy for people who have symptoms of anxiety or depression. IAPT stands for 'Improving Access to Psychological Therapy'. They give priority to pregnant women and new parents. This leaflet explains more about the service and the help we can offer you if you need it.

It is common for pregnant women and new parents to experience:

- Low mood, sadness and fearfulness
- Anxiety, worry and tension
- Irritability and anger
- Difficult or unexpected feelings towards your pregnancy or baby
- Poor sleep even when your baby sleeps well
- Feeling unable to cope or enjoy anything
- Thoughts that you are not a good enough parent
- Worrying thoughts about your baby
- Anxiety about labour or struggling to come to terms with a difficult labour.

Asking for help

It can be difficult to talk about how you are feeling and ask for help. Common reasons for this are:

- You may not know what is wrong
- You may feel ashamed that you are not enjoying your baby or coping as you believe you should
- You may worry that your baby will be taken away.

Struggling emotionally at this time can happen to anyone. It is not your fault.

Asking for help doesn't mean you can't cope or are not able to care for your child. It's the start of getting the right help and support to ensure you can be the parent you want to be. It is very rare for babies to be taken away from parents, so you should not worry about this.

How an IAPT service can help you

IAPT offers short-term talking therapy to give you space to talk. The types of therapy offered will vary depending on your local IAPT service. These may include guided self-help sessions with a therapist, cognitive behaviour therapy, couples therapy and counselling.

How to contact IAPT

You can refer yourself to IAPT by phoning your local service directly. Contact details for all London services can be found at the end of this leaflet. You may find it hard to contact us yourself. In this case, ask your midwife, health visitor, friends or a family member to help you make that first call. Your GP can also make the referral. We know that pregnancy and the first year of your baby's birth is a very important time. We will offer you an assessment and treatment as soon as possible.

EXPERIENCE BASED, CO-DESIGN WORKSHOP



#MindNBodyLdn #MatExp

SCREENING FOR TOKOPHOBIA IN PREGNANCY

Midwives have a crucial role to play

Simple questions at booking and subsequent appts:

How do you feel about your pregnancy?

How / where would you like to give birth?

How was your previous birth experience?

Observe the woman's **physical response**

Active listening

Refer on for specialist assessment and support if there is a positive screening response

HOW CAN WE ASSESS TOKOPHOBIA?

Tokophobia can be assessed and diagnosed by **any professional** with perinatal mental health knowledge by taking a **careful clinical history**, and by using **assessment measures**:

Clinical history

Fear of Childbirth Visual Assessment Scale (FOC VAS)

Fear of Birth Scale (FOBS)

Wijma Delivery Expectancy / Experience Questionnaire (WDEQ-A)

Impact of Events Scale Revised (IES-R) for PTSD

FOC VAS

The Fear of Childbirth Visual Assessment Scale

How do you feel about your forthcoming birth?

I have a calm feeling

(VAS = 0)



I am really horrified

(VAS = 10)

FOBS

- Scale ranges from 0-100, scores averaged
- A score over 50 suggestive of birth fear

How do you feel right now about the approaching birth?
Please mark with an X on the lines below.

Calm	_____	Worried
No fear	_____	Strong fear

WIJMA DELIVERY EXPECTANCY / EXPERIENCE Q

Measure the thoughts and feelings women may have at the prospect of labour and birth

Uses 6 point Likert scale with end points 'Not at all' and 'Extremely'

Reverse scoring for 50% of questions Minimum score 0; Maximum score 165

>85 indicative of tokophobia

100+ severe tokophobia

How do you think your labour and delivery will turn out as a whole?

0 1 2 3 4 5

Extremely fantastic

Not at all fantastic

0 1 2 3 4 5

Extremely frightful

Not at all frightful

How do you think you will feel in general during the labour and delivery?

0 1 2 3 4 5

Extremely lonely

Not at all lonely

0 1 2 3 4 5

Extremely strong

Not at all strong

0 1 2 3 4 5

Extremely confident

Not at all confident

IMPACT OF EVENTS SCALE

General PTSD assessment tool

22 questions using a 5 point Likert scale to assess symptoms

24 or more	PTSD is a clinical concern. ⁶ Those with scores this high who do not have full PTSD will have partial PTSD or at least some of the symptoms.
33 and above	This represents the best cutoff for a probable diagnosis of PTSD. ⁷
37 or more	This is high enough to suppress your immune system's functioning (even 10 years after an impact event). ⁸

The City Birth Trauma Scale – new assessment tool not in use yet but looks very promising (Ayers et al 2018)

WHEN TO REFER ON:

Many women with **mild or moderate anxiety** may be managed by **tailored support in maternity** i.e. through a Specialist Mental Health Midwife / Consultant Midwife

Refer on if:

- **Indications for psychological therapy:** secondary tokophobia, post-traumatic stress disorder or other mental health problems such as anxiety or depression
- **Indications for multidisciplinary mental health input:** tokophobia that is very severe, complex, has multiple other mental health comorbidities which are also severe, or there are high levels of risk to mother and baby

WHAT INTERVENTIONS HELP? THE EVIDENCE BASE...

A wide variety of interventions have been investigated: the evidence base is patchy

Challenges: Different definitions of tokophobia, heterogeneity of presentation, comorbidity

Outcomes include reduction of fear, satisfaction with intervention, birth choice

Evidence for group-based psychoeducation with relaxation (Saisto et al., 2006; Rouhe et al., 2013, 2014, 2015)

Some evidence for CBT including internet-based CBT (Nieminen et al., 2016)

Birth trauma/secondary tokophobia extrapolated evidence base of TF- CBT and EMDR plus case studies

Striebich, S., Mattern, E., & Ayerle, G. M. (2018). Support for pregnant women identified with fear of childbirth (FOC)/tokophobia—A systematic review of approaches and interventions. *Midwifery*, 61, 97-115.

ANTENATAL PATHWAY — PAN LONDON TOKOPHOBIA TOOLKIT 2018

Guidance document to support best practice

<https://www.healthylondon.org/wp-content/uploads/2018/01/Tokophobia-best-practice-toolkit-Jan-2018.pdf>

Healthy London
Partnership

NHS
London
Clinical Networks

**Pan-London Perinatal
Mental Health Networks**

**Fear of Childbirth (Tokophobia) and
Traumatic Experience of Childbirth:
Best Practice Toolkit**

January 2018

Effective date: 31/01/2018
Due for review: 1/04/2019

BEST PRACTICE GUIDANCE FOR CARE WITHIN A MATERNITY SERVICE

TIMELINE OF CARE	Preconception	Booking 8-12 weeks or at 16 week midwife appointment	Antenatal Care 12-32 weeks	Antenatal Care 32 weeks	Intrapartum Care	Postnatal Care
Interventions	<p>Access to consultation e.g. Specialist Mental Health Midwife/ Consultant Midwife. Information about tokophobia and care pathways. Access to discussion about previous delivery. If necessary, refer for psychological therapy in IAPT (if mild to moderate) or Community Mental Health/ Psychology Services (if severe/complex).</p>	<p>Routine assessment of fear of childbirth. Appointment with Specialist Mental Health Midwife/ Consultant Midwife or other perinatal mental health professional. If necessary refer for psychological therapy in Maternity, IAPT or Perinatal Community Mental Health Services (see text for guidance). Information leaflets. Tokophobia/trauma clearly identified on notes e.g. coloured sticker.</p>	<p>Early appointments with obstetrician. Specialist appointments (e.g. with anaesthetist) if appropriate. Birth/care plan collaboratively formulated. Continuity of carer (midwifery caseloading). Continue psychological therapy in Maternity/IAPT/Perinatal Community Mental Health Services.</p>	<p>Individualised birth care plan finalised, including medical and psychological aspects of care. Familiarisation visit to labour ward/birth centre. Psychoeducation about childbirth and relaxation may be helpful. Continue psychological therapy in Maternity/IAPT/Perinatal Community Mental Health Services.</p>	<p>Implementation of birth care plan. Handover includes birth care plan.</p>	<p>Postnatal follow up e.g. with Specialist Mental Health Midwife/ Consultant Midwife. Screen for birth trauma/PTSD. Assess mother-baby relationship. Access to information about birth/birth reflections appointment. If there are PTSD symptoms relating to the birth, refer for trauma-focused CBT or EMDR in IAPT (if mild to moderate) or in Perinatal Community Mental Health Services (if severe/complex).</p>

SUPPORTING WOMEN WITH BIRTH FEAR: ISSUES TO CONSIDER

Women may not recognise the extent of their anxiety until quite late in pregnancy

Long time between 16 & 28 weeks without seeing a midwife – only identified then and too late for CBT or trauma-focused talking therapies prior to baby's due date

Confusion re. referral pathways as often raised as '*a maternal request for CS*'

Distressed mother, stressed health care professional

MRCs will not 'cure' PTSD or may not be the ideal birth for the woman

Important to reduce fear and anxiety rather than just managing their mode of birth

Not all women disclose their fear easily (denial about birth), lack of continuity of care inhibits disclosure

Is a CS the answer??

NICE GUIDANCE

1.8.7 For a woman with tokophobia (an extreme fear of childbirth), **offer an opportunity to discuss her fears** with a healthcare professional with expertise in providing perinatal mental health support in line with section 1.2.9 of the guideline on caesarean section (NICE guideline CG132).

- 7.7.1.19 Offer women who have **post-traumatic stress disorder**, which has resulted from a traumatic birth, miscarriage, stillbirth or neonatal death, a **high intensity psychological intervention** (trauma-focused CBT or eye movement desensitisation and reprocessing [EMDR]) in line with the guideline on posttraumatic stress disorder (PTSD) (NICE clinical guideline 26).

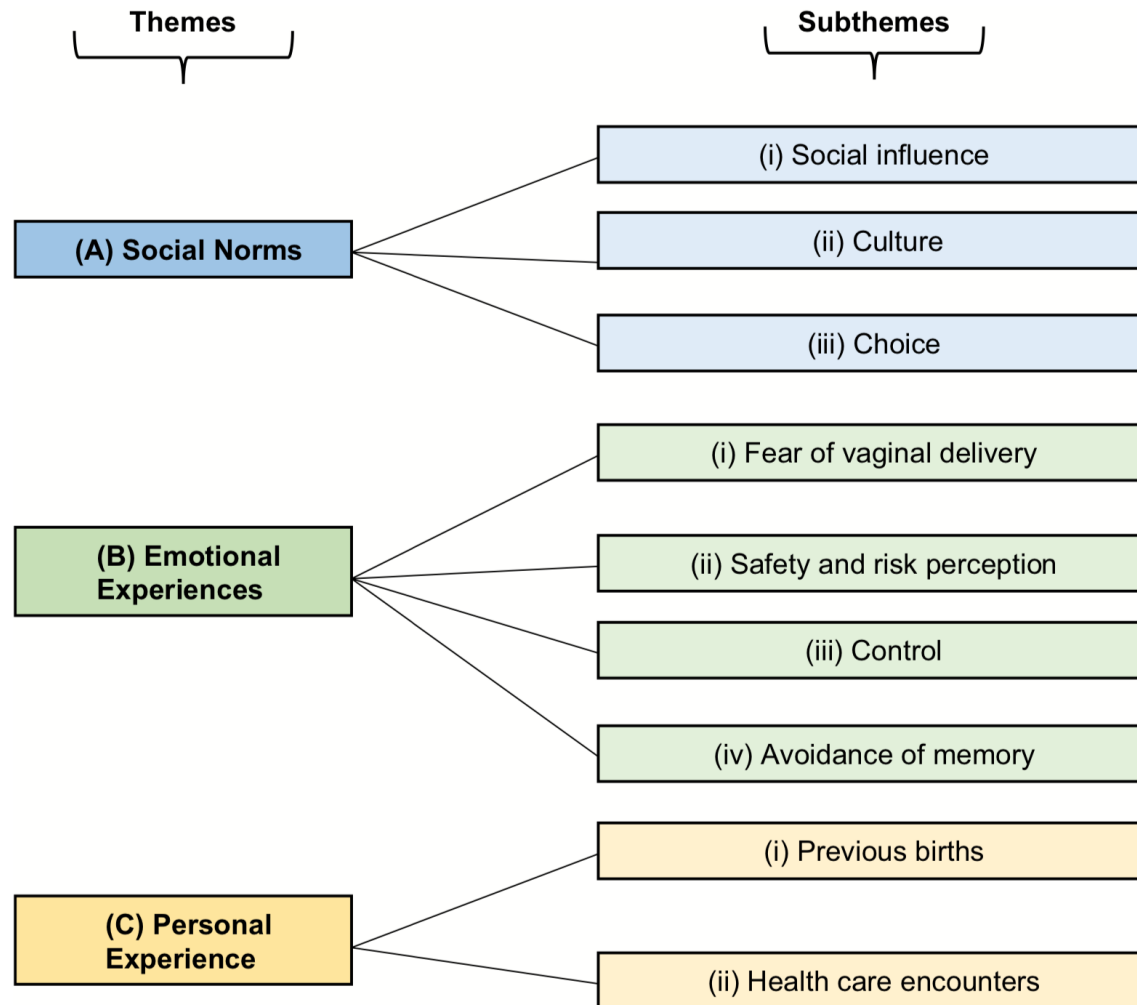
MATERNAL REQUEST CS FOR TOKOPHOBIA

It's not a 'cure' for tokophobia but a request should be supported

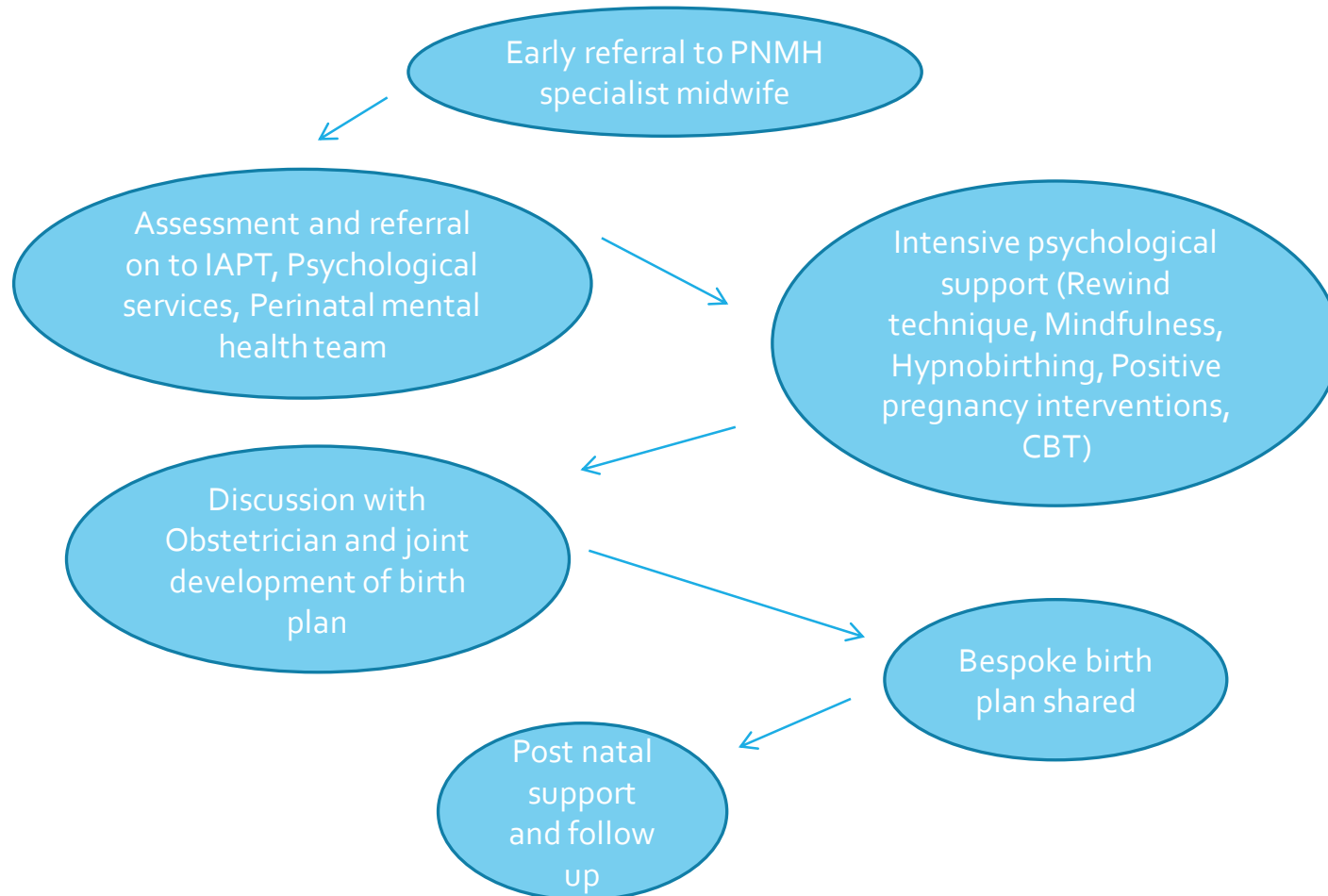
Locally from 2016 – antenatal care pathway for women requesting a CS without obstetric indication, with the aim of:

- **Consistent** clinical care and management by offering 'best practice'
- Improve **birth experience** for women and **reduce associated fear/anxiety**
- **Diagnosing and treating** anxiety and PTSD
- Supporting physiological birth whilst maintaining **psychological safety**

MANY REASONS FOR WANTING A MRCS

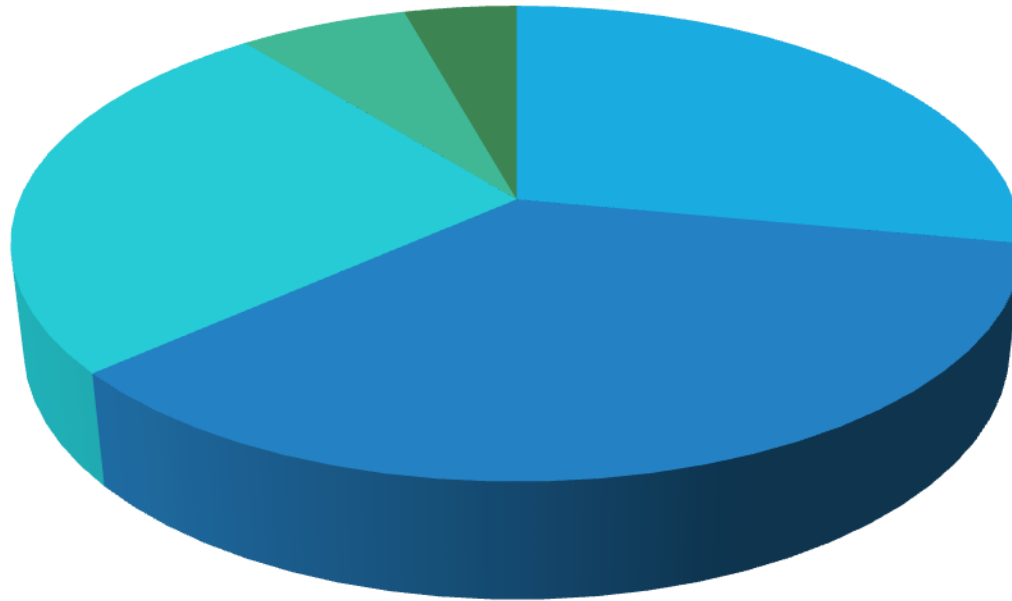


KEY FEATURES OF PATHWAY



REASON FOR MRCS AFTER ASSESSMENT

Over 150 women have been supported approx. 50:50 first birth and subsequent births



■ Tokophobia

■ Birth Trauma / PTSD

■ Birth fear / anxiety

■ Vaginismus

■ Psychiatric conditions

INTERVENTIONS PROVIDED

Women referred from 8-40 weeks. Median 21 weeks

Median of 3 appointments with PNMH MW (range 1-8)

24% referred to IAPT (NHS Talking Therapies)

21% referred for Rewind Therapy

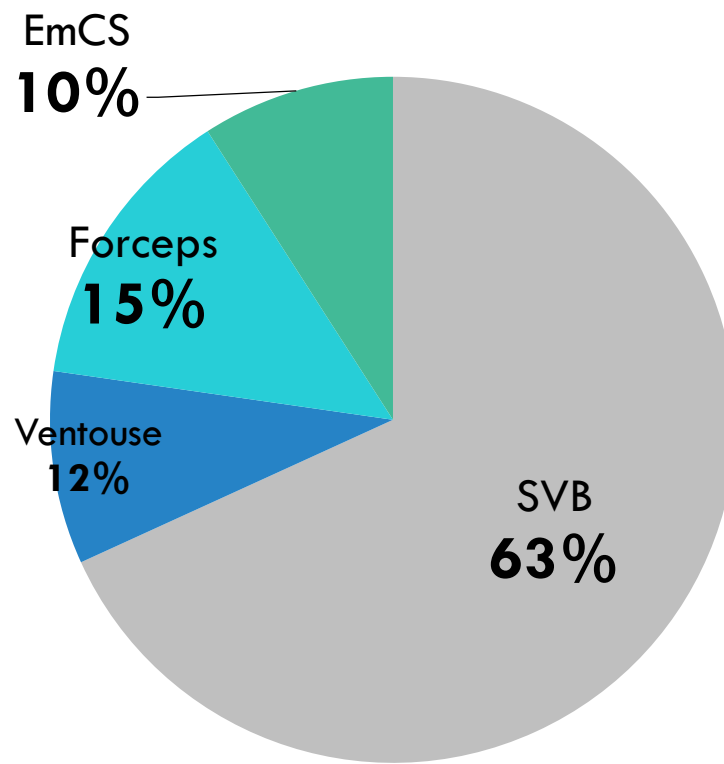
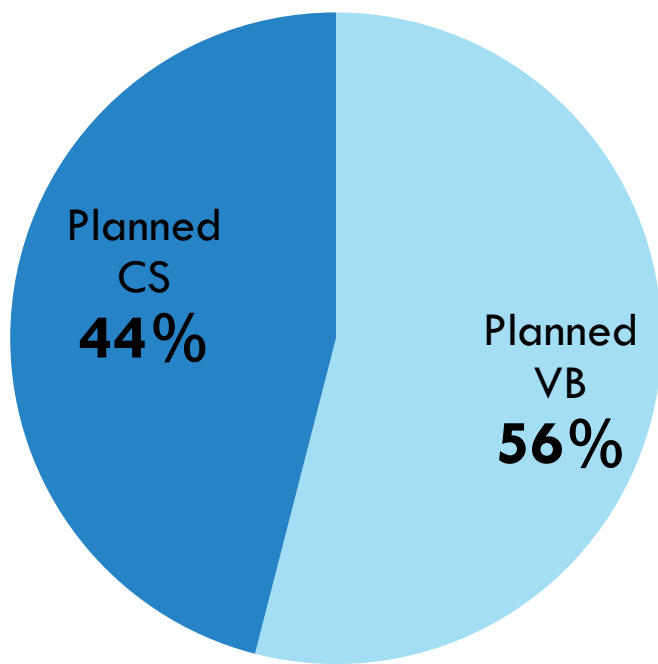
5% referred to Perinatal Psychologist

45% continued sessions with PNMH midwife

18% yoga and mindfulness sessions

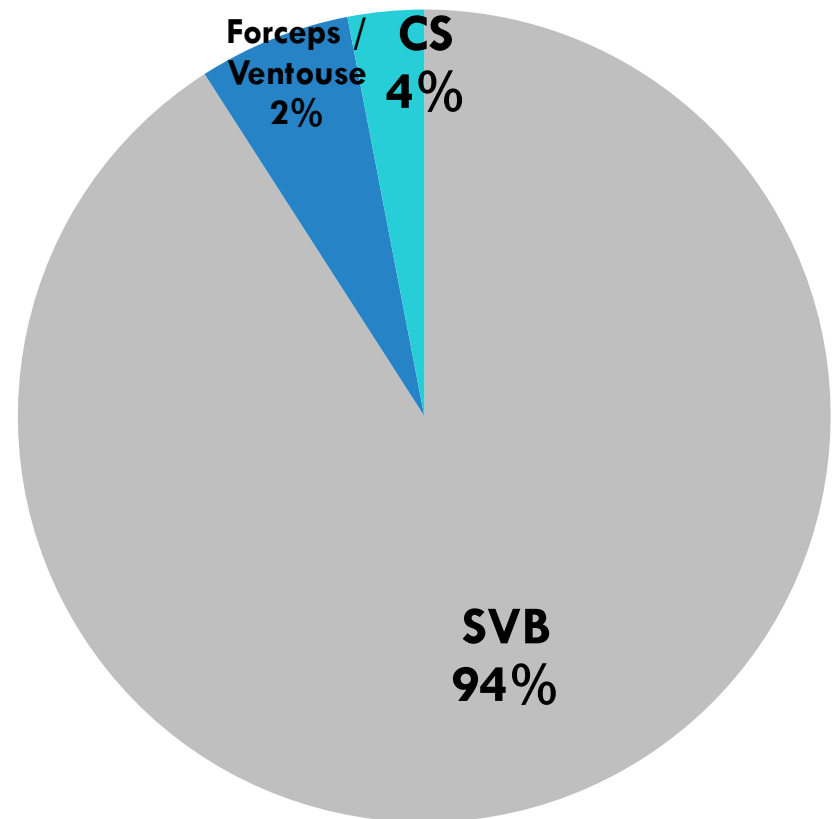
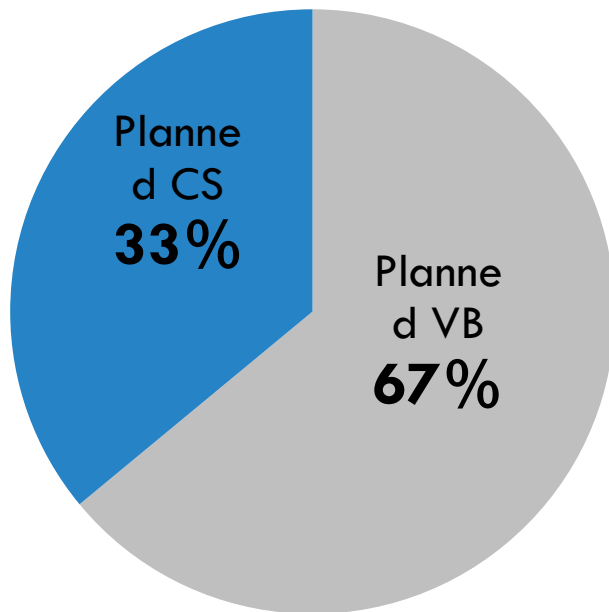
BIRTH PLANS AFTER SUPPORT AND OUTCOMES FOR FIRST BIRTHS —

90% women achieved a vaginal birth who planned one



BIRTH PREFERENCE FOR MULTIGRAVIDA AFTER SUPPORT AND BIRTH OUTCOMES

100% women who laboured achieved a vaginal birth



OUTCOMES OF THE MRCS PATHWAY

Pathway is providing **consistent** clinical care and management

100% women express **positive feedback** with the pathway from decision making and their birth experiences

Diagnosing and treating anxiety and PTSD

Request for MRCS strongly linked to an underlying psychological / psychiatric disorder

Development of **supportive culture**

Reducing physical risk without negative impact on psychological wellbeing - **improving birth outcomes**

WOMEN'S EXPERIENCES

**100% of women
reported a very
positive birth
experience
postnatally**

With your support and encouragement I changed my mind – I was very scared but everyone knew how I felt and were lovely

You helped me realise it was possible to have a good experience and achieve the birth I'd always dreamed of

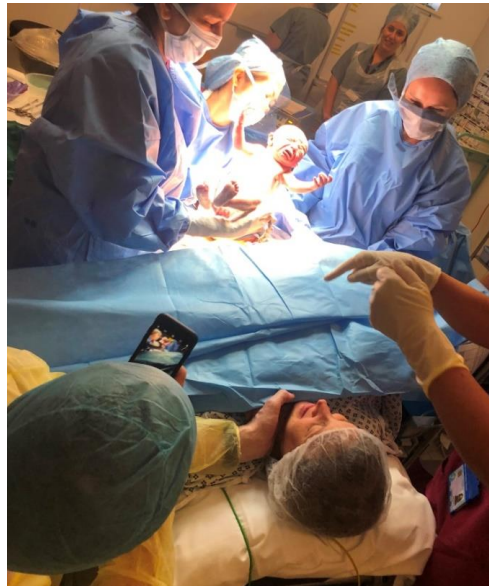
My first birth was so horrific I really dreaded this birth but the care and support this time was amazing

Thank you for really listening and understanding my fears. My CS was a wonderful day

I am delighted that I changed my mind! My birth was fantastic and I'm so glad I listened to you

CAESAREAN BIRTH TO ACHIEVE A POSITIVE OPERATIVE BIRTH

**Fear of birth does not
disappear when CS
agreed – just as much
support needed during
the birth**



We cannot thank you enough for all the care and support you showed us. You really made an occasion I've dreaded all my life an experience which I can reflect on with great happiness. That means the world!

HOW CAN MATERNITY SERVICES SUPPORT WOMEN WITH BIRTH TRAUMA?

The issues....

Birth trauma often only identified during the next pregnancy

Often associated with a MRCS due to the previous birth

Increasingly evident that a cohort of women with birth fear and birth trauma slip through the PNMH treatment gaps – too late for CBT or wait time too long, or not ‘ill’ enough for specialist PNMH services

.... but they are sitting in front of us in our antenatal clinic – do we just agree to the CS?

Or could the ‘Rewind Technique’ be an answer?

WHAT IS THE REWIND TECHNIQUE?

- This is a brief psychological intervention for trauma release in women experiencing symptoms of birth trauma in relation to a previous birth or birth phobia
- This process gently neutralizes the fear (and other negative feelings) that have been associated with the birth, once the person is in a state of deep relaxation and enables them to recall the birth and then rewind it in 3 ways (double-dissociated, dissociated and associated) and ends with positive future focus visualisation.
- This process can then allow for positive birth planning
- It can be performed by any birth worker who has had specific trauma training

REWIND TECHNIQUE — PART OF AN INNOVATIVE TRAUMA-INFORMED APPROACH AT C&W TRUST

Specialist PNMH midwives at C&W Hospital NHS Trust offer the Rewind technique as an intervention (if appropriate after MH assessment) to antenatal women to help relieve trauma symptoms and allow for positive birth planning for their subsequent birth

This is part of a multidisciplinary antenatal pathway developed in 2016 this has helped treat underlying mental illness, working alongside IAPT and Specialist PNMH services.

It has reduced the MRCS rate due to birth fear/trauma, by over 50%

100% positive birth experiences reported by women.

All women express positive feedback with the pathway for support with decision making and their birth experiences

REWIND AUDIT RESULTS:

141 women treated over 3 years

Almost all were MRCS

92% successful reduction in reported anxiety

Optimising normal birth:

intervention led to 69% planning vaginal birth

121 have given birth so far:

74 successful VBs

7 CS for breech, unstable lie, intrapartum events

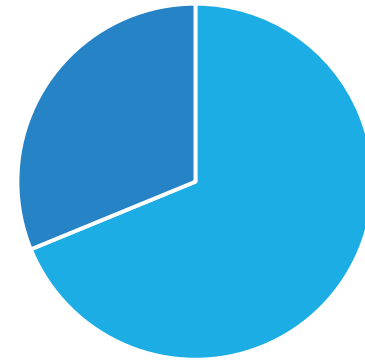
Audit results:

No harm from Rewind but significant reduction in birth-related anxiety

Can reduce physical risk without negative impact on psychological wellbeing

BUT: more formal research needed to confirm local findings

Planned Birth after Rewind



■ Planned VB = 97 ■ Planned CS = 44

One size doesn't fit all – we need to hold women at the centre of our care and offer a range of options to suit them and the degree of symptoms



CARE PLANNING FOR A POSITIVE BIRTH

WHAT IS A POSITIVE BIRTH EXPERIENCE?

Most women want a positive birth experience that fulfils their personal and socio-cultural beliefs and expectations. Attitudes towards interventions in childbirth have changed and are related to cultural and health system influences e.g. differences between countries

May be normal in some cultures to have a CS due to perceived 'safety'. Culture of fear can be passed down through generations

They want to give birth to a healthy baby in a physically and emotionally safe environment with practical & emotional support from birth companions, and competent, reassuring, kind clinical staff.

WHAT IS A POSITIVE BIRTH EXPERIENCE?

Women's birth experiences change over time & most become more positive after 1 year.

Respectful individualized midwifery care focused on the woman and keeping birth normal increases positive perceptions of the birth experience.

Keeping women's attitudes, beliefs and choices at the centre of care.

Maternity care should be designed to ensure that safety & psychosocial well-being are equally valued to support a positive experience

HOW TO CONDUCT A PSYCHOLOGICALLY-MINDED CARE PLANNING DISCUSSION

Active listening and acknowledging skills are key

Allow more time than you think

Use appropriate language

Understand and respect her experiences, culture, beliefs and knowledge

Have a good understanding of symptoms and emotional effects of tokophobia (and birth trauma)

HOW TO CONDUCT A PSYCHOLOGICALLY-MINDED CARE PLANNING DISCUSSION

Have a good understanding of the latest evidence and risks

Be able to explore alternatives and have realistic discussions – explore all likely scenarios and make contingency plans

Respect that the final decision rests with the woman

If fear due to birth trauma – be aware that the subsequent birth has the power to heal or re-traumatise

Create a clear written plan for her notes

CARE PLANNING CONSIDERATIONS — MIND YOUR LANGUAGE

Be aware of the language of ‘risk’

Obstetricians and midwives may be particularly ‘cautious’ regarding risk

We need to be wary not to ‘inflate’ risks

Try to use absolute risk rather than relative risk

We need to try and individualise risk as much as possible

CARE PLANNING CONSIDERATIONS — MIND YOUR LANGUAGE

Alternative risk words may be less scary and coercive
e.g. likelihood, chance, possibility

Evidence-based information — policy, protocol and
guideline often used interchangeably

Birthrights and NHS England have been working
together to co-produce a consent tool for intrapartum
care this iDecide, which was tested with healthcare
professionals, women and their partners in early 2019.
Feedback is currently being reviewed and further plans
are being made to pilot and roll out the tool nationally.

We don't have to agree with a woman's decision but
must **support it**

AFTER THE BIRTH

Postnatal follow-up is important

Many anxieties may have resolved

Reflect on what happened during birth, whether predictions were disconfirmed, what she learned about her ability to cope

Check for traumatic experience of birth and PTSD symptoms

Assess relationship with the baby

Later consider implications for any future pregnancy / birth



CASE STUDIES

Claire

Anna

CLAIRE'S CARE PLAN

Fearful since early childhood

Double contraception for 3 years to avoid pregnancy

Pre-pregnancy referral from IAPT for support as accessed CBT to help cope with a pregnancy

Struggled to be in maternity unit, care off site initially

Early decision for CS

Frequent appts/calls in pregnancy

Grounding techniques and music in theatre, positive experience

Has since had a 2nd birth

ANNA'S CARE PLAN

Previous traumatic birth

Pelvic floor dysfunction

Emotional distress

Strong need to have agency over decision

Support to know she can refuse forceps

Wants a calm, safe birth

Wants control over analgesia, planned IOL

KEY MESSAGES

Tokophobia is very important in relation to experience of childbirth and subsequent mental health problems, particularly **birth trauma and PTSD**

Can be categorised as **primary or secondary tokophobia** (PTSD after birth) depending on time of onset

Early identification and signposting is crucial to allow time for intervention

Psychologically informed birth preferences (birth plan) can make a huge difference to birth experience and reduce the risk of re-traumatisation

Refer to the Tokophobia Toolkit for further information e.g. Caesarean section for non-medical reasons

Postnatal follow up is equally important

THANK YOU



ANY QUESTIONS?