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”.

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

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**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
- Wednesday 12th September
- Wednesday 24th October
- Wednesday 14th November
- Wednesday 12th December

9:30-10:30am
Queen Mary Maternity Unit, Antenatal Clinic
5 Ward, Medicine, London E12 0EB
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

‘Dads To Be’ Class

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

What 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 were home, how will we juggle time, sleep, new roles, energy, work, money, sex, and parents?

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

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 dads2be.org
CULTIVATING WELLBEING
DAY AT THE SALOPIAN KITCHEN GARDEN
PREGNANCY AND YOUR MENTAL HEALTH AND WELLBEING

We are here to help

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 online resources.

Ask your midwife, GP or obstetrician for more information.

My pregnancy & post-birth wellbeing plan

This plan is to help you prepare for the support you might need during your pregnancy. While coping with physical changes in pregnancy, birth and beyond, your emotional health is important too. Having a healthy pregnancy and birth, mentally and emotionally is important to wellbeing.

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 raised 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:

- Feeling overwhelmed
- Feeling Marioning more often
- Lack of concentration
- Change of appetite
- Problems sleeping or insomnia
- Feeling thoughts
- Feeling more anxious
- Feeling hopeless
- Lack of control at times

Some women can also have:

- Irritative thoughts
- Violent thoughts
- Strict rituals and obsessions
- Lack of feeling for their baby

Talking about how you are feeling helps you get through the exciting and challenging time of becoming a parent. It doesn’t matter who you talk to; 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 you and accepting that you are unwell.

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

You may want to tell your partner, family or friends about how you are feeling. Sometimes it can be helpful to talk to a professional who can help you understand your feelings and support you.

Am I the sort of person who accepts that I am unwell?

It is normal to feel overwhelmed and anxious during pregnancy. It is important to accept that you are unwell and seek help if needed.

How might I start the conversation of things troubling me?

It can be difficult to talk about how you are feeling and ask for help. Here are some tips to help you start the conversation:

1. Write down your thoughts and feelings before you talk to anyone.
2. Choose a time and place where you feel comfortable and can have a private conversation.
3. Practice what you want to say and how you want to say it.
4. Be honest and open about how you are feeling.
5. Ask for help and support from someone you trust.

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

Emotional support can be very helpful. It can be difficult to talk about your feelings and ask for help. However, it is important to know that you are not alone.

It is common for pregnant women and new parents to experience feelings of anxiety, depression or other emotional challenges. As a new parent, you may experience a range of emotions such as excitement, worry, exhaustion, and confusion. It is important to remember that everyone copes in their own way.

If you need help or support, there are many resources available for pregnant women and new parents. It is important to seek help and support when needed.

For more information, please visit the NHS website or contact your local health visitor.

Tommy’s

Tommy’s has support information for both women and partners who have experienced a traumatic birth experience.

Embarking on this journey can be a very special time. However, it can also be a challenging time. As you adapt to the new role of a parent, you may experience a range of feelings. It is important to seek help and support when needed.

For more information, please visit the Tommy’s website or contact your local health visitor.
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
The Fear of Childbirth Visual Assessment Scale

How do you feel about your forthcoming birth?

I have a calm feeling  

I am really horrified

(VAS = 0)  

(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
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
IMPACT OF EVENTS SCALE

General PTSD assessment tool

22 questions using a 5 point Likert scale to assess symptoms

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

ANTENATAL PATHWAY — PAN LONDON

TOKOPHOBIA TOOLKIT 2018

Guidance document to support best practice


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

<table>
<thead>
<tr>
<th><strong>Interventions</strong></th>
<th><strong>Preconception</strong></th>
<th><strong>Booking 8-12 weeks or at 16 week midwife appointment</strong></th>
<th><strong>Antenatal Care 12-32 weeks</strong></th>
<th><strong>Antenatal Care 32 weeks</strong></th>
<th><strong>Intrapartum Care</strong></th>
<th><strong>Postnatal Care</strong></th>
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<tr>
<td>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).</td>
<td>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 guide). Information leaflets. Tokophobia/trauma clearly identified on notes e.g. coloured sticker.</td>
<td>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.</td>
<td>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.</td>
<td>Implementation of birth care plan. Handover includes birth care plan.</td>
<td>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).</td>
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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??
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

(A) Social Norms
- (i) Social influence
- (ii) Culture
- (iii) Choice

(B) Emotional Experiences
- (i) Fear of vaginal delivery
- (ii) Safety and risk perception
- (iii) Control
- (iv) Avoidance of memory

(C) Personal Experience
- (i) Previous births
- (ii) Health care encounters
Early referral to PNMH specialist midwife

Assessment and referral on to IAPT, Psychological services, Perinatal mental health team

Intensive psychological support (Rewind technique, Mindfulness, Hypnobirthing, Positive pregnancy interventions, CBT)

Discussion with Obstetrician and joint development of birth plan

Bespoke birth plan shared

Post natal support and follow up

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

Planned CS 44%
Planned VB 56%

SVB 63%
Forceps 15%
Ventouse 12%
EmCS 10%
BIRTH PREFERENCE FOR MULTIGRAVIDA AFTER SUPPORT AND BIRTH OUTCOMES

100% women who laboured achieved a vaginal birth

Planned VB 67%
Planned CS 33%

SVB 94%
CS 4%
Forceps/Ventouse 2%
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

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.

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

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.

100% of women reported a very positive birth experience postnatally.
Fear of birth does not disappear when CS agreed – just as much support needed during the birth.
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
**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 2\textsuperscript{nd} 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?